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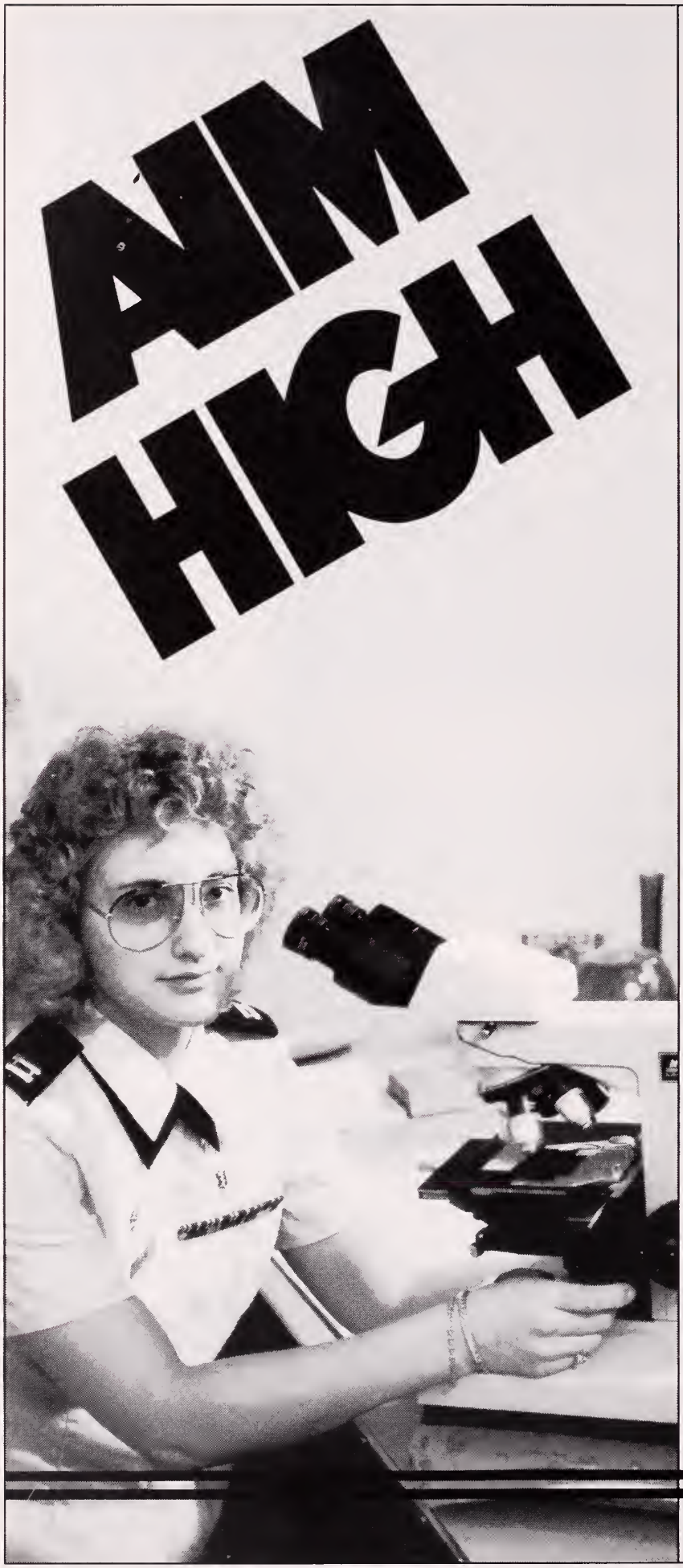

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Proper Perspectives

The Kentucky General Assembly convenes in Frankfort on January 2, 1990, and faces a bewildering array of issues. The 1990 Session, which many experts believe will be a pivotal point in Kentucky's history, may establish the Commonwealth's agenda for the next 100 years.

The Kentucky Supreme Court has ruled the entire school system unconstitutional and has given the General Assembly until July 1, 1990, to completely overhaul, restructure, and fund the rebuilt system. Both federal and state courts threaten the state's prison system with massive fines and penalties over treatment of inmates and lack of housing. An underfunded and deteriorating human services program faces deep cuts without infusion of new federal and state dollars. A highway system in which Kentucky justifiably has taken great pride crumbles from years of neglect, and numerous secondary and rural bridges need to be repaired or replaced. Urban and county governments faced with declining federal revenue look to Frankfort for assistance to continue providing basic services.

It has been estimated that a minimum of $800 million in additional revenue will be needed to address these imbalances. Federal dollars dry up as Washington wrestles with its overwhelming debt. Alcohol, tobacco, coal, and horse racing, historically the foundations of Kentucky's revenue base, continue to decline, and they, too, look to the state for assistance and economic incentives.

Other concerns include a growing indigent population estimated to exceed 300,000 people with no health insurance, no money, and no way to pay for health care. Their only hope is a benevolent society and a charitable health system. Our youngest and brightest, faced with few career options, leave their communities in search of a better tomorrow. Kentucky's aging population, which on a percentage basis exceeds most other states, finds nursing homes and other custodial institutions full. The homeless population, which now includes as many women and children as men, continues to confound public officials and overflow missions and temporary housing.

'The 1990 Session, which many experts believe will be a pivotal point in Kentucky's history, may establish the Commonwealth's agenda for the next 100 years.'

Resolutions to these overwhelming problems are frustrated by the political infighting between the legislature and the Executive branch. A political storm is building over gubernatorial succession which may threaten any opportunity that may exist to resolve critical issues confronting Kentucky. General Assembly members face primary elections within 45 days of adjournment of the Session following votes on critical and devisive economic and social issues. Add other controversial issues, such as abortion, gun control, assault weapons and certificate of need, and you then begin to comprehend the awesome task 138 men and women of the General Assembly face.

'While medicine's issues are legitimate and deserve consideration, they must be kept in proper perspective. In this tension-packed atmosphere, those issues KMA presents that truly magnify patients' concerns will be given priority by the KGA.'

'Events in the 1990s which President Nelson Rue has labeled the "Decade of Decision" will affect our state for years to come. Let's work on medical issues, but just as importantly, let us concentrate on assuring Kentucky's future for our children and our children's children.'

Into this quagmire marches over 200 special interest groups and approximately 500 lobbyists pursuing their special agendas, many of which will conflict with KMA's views.

The scenario which has been described is a snapshot of the situation as it will exist during the hectic 60 legislative days between January 2 and April 12. While medicine's issues are legitimate and deserve consideration, they must be kept in proper perspective. In this tension-packed atmosphere, those issues KMA presents that truly magnify patients' concerns will be given priority by the KGA.

Keep informed during the Session, exercise your constitutional rights, and participate fully in the Democratic process. Kentucky's future lies in the balance. Events in the 1990s which President Nelson Rue has labeled the "Decade of Decision" will affect our state for years to come. Let's work on medical issues, but just as importantly, let us concentrate on assuring Kentucky's future for our children and our children's children.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
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Carcinoma of the Prostate Simulating Primary Bladder Cancer

Mohammad Amin, MD; Walter Broghamer, MD; Elizabeth A. Amin, MD

After encountering two patients who were diagnosed as having primary bladder cancer but were ultimately found to have carcinoma of the prostate invading the bladder, a prospective study was undertaken. In five patients with known carcinoma of the prostate invading the bladder, cup biopsies of the bladder lesions were reported as primary bladder cancer in four patients. To prevent this error, immunohistochemical studies are required and discussed in this paper.

It is not unusual for the carcinoma of the prostate to invade the rectosigmoid or the urinary bladder. When a biopsy is taken from the rectosigmoid or the urinary bladder lesion without the knowledge of prostatic tumor, a misdiagnosis of primary tumor of rectosigmoid or urinary bladder has been made.[1,2] As there are marked differences in the prognosis and treatment, it is essential that a correct diagnosis be made in these situations. We encountered two patients who were diagnosed as having bladder carcinomas by the urologists as well as the pathologist after the conventional histopathological examination of the bladder biopsy. These patients were ultimately found to have carcinoma of the prostate invading the urinary bladder. On initial physical examination, the prostate was considered to be benign by the urologist.

These cases stimulated us to carry out a study in five patients where a carcinoma of the prostate was invading the urinary bladder. A cup biopsy of the lesion from the urinary bladder was sent to the pathologist without providing the full history and requesting only to rule out bladder tumor.

Case Reports

Case 1

A 68-year-old man was admitted to the hospital with gross painless hematuria. The excretory urogram was unremarkable. Cystoscopy demonstrated a urethral stricture, which was easily dilated, and a lesion in the trigone of the bladder was suspicious of carcinoma. Several cup biopsies of this lesion were obtained and the prostate was considered to be benign. The bladder biopsy was reported to be invasive transitional cell carcinoma, grade II (Fig 1). The patient was advised to have radical cystectomy, but he refused and was lost to follow-up. He came back to the hospital a year later in urinary retention. The prostate was hard and fixed during this examination. The acid phosphatase was elevated, and bone scan showed widespread osteoblastic metastatic disease. The excretory urogram showed bilateral lower ureteral obstruction. Transurethral resection of the prostate and areas of trigone showed poorly differentiated prostatic carcinoma (Fig 2). Prostatic acid phosphatase (PSAP) immunoperoxidase stain was weakly positive, but prostatic specific antigen (PSA) stain was negative. He was treated with Stilphostrol® but died within three months after a downhill course. This case was previously reported in the *Urologists' Letter Club*.[3]

Case 2

A 66-year-old man with hematuria was first seen by a urologist in Chattanooga, Tennessee. The excretory urogram showed left ureteral obstruction near the bladder. Transureteral biopsy of a

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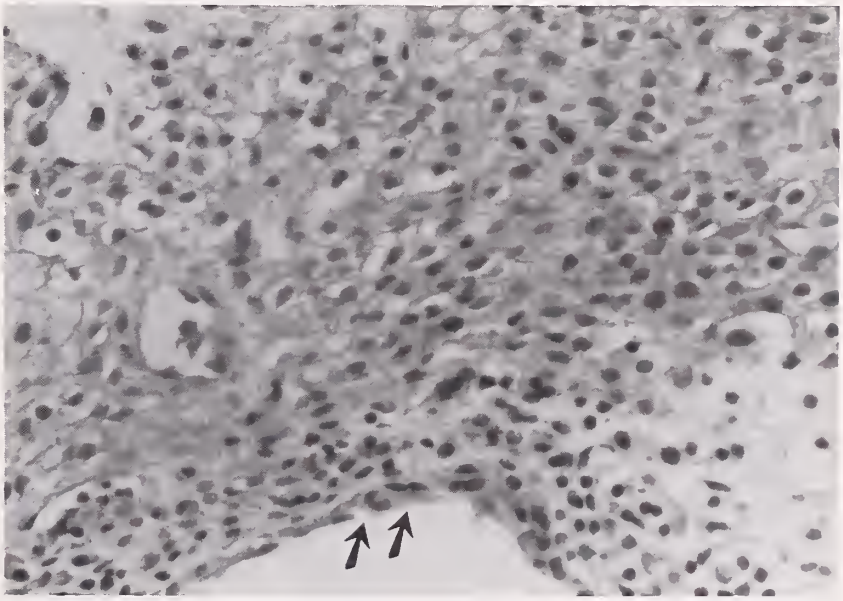

Fig 1 — Urinary bladder biopsy. A single layer of atrophic urothelium surfaces infiltrating poorly differentiated carcinoma of the prostate. V. Hematoxylin-eosin (400X). This was reported to be invasive transitional cell carcinoma.

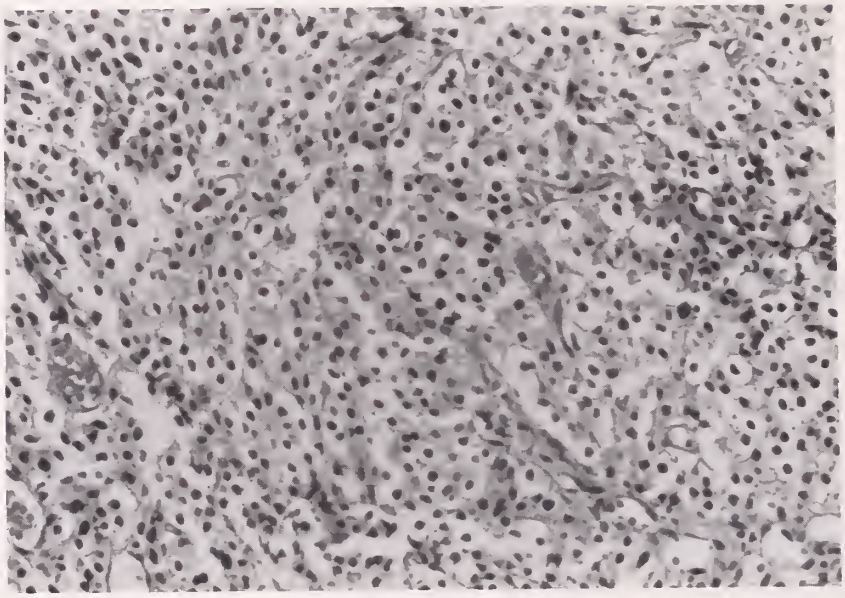

Fig 2 — Prostate, transurethral shaving. The presence of perinuclear clear areas in the neoplastic tissues of the primary cancer was a prominent histologic feature also observed in those extending into the wall of the urinary bladder. Hematoxylin-eosin (400X).

Fig 3 — Retrograde urogram showing bilateral lower ureteral obstruction.

lesion in the lateral wall of the bladder was reported by the pathologist as a poorly differentiated transitional cell carcinoma. He was treated with external beam radiotherapy. The records from the hospital also showed that a consultation with a medical oncologist from Memorial Sloan Kettering in New York was obtained, and the patient was started on a chemotherapy protocol for the carcinoma of the bladder.

We saw him a year later with marked frequency and dysurea. The excretory urogram retrograde study showed bilateral ureteral obstruction (Fig 3). The serum acid phosphatase and bone scan were within normal limits. The prostate was firm and fixed on rectal examination. Transurethral resection of bladder lesion and prostate was carried out for biopsy purposes as well as needle biopsies, which were obtained from the prostate (Figs 4,5). All of these specimens contained results consistent with carcinoma of the prostate invading the bladder. The patient was started on hormone therapy.

Prospective Study

In the past three years, five patients were seen at the University of Louisville Hospitals with carcinoma of the prostate with bladder invasion. At the time of cystoscopy, cup biopsies from the bladder lesion were sent for routine histologic study. All patients also had either transurethral resection of the prostate for obstructive symptoms or needle biopsies of the prostate, but this tissue was withheld until the bladder biopsy had been examined and reviewed with the pathologist. PSAP and PSA immunoperoxidase stains were performed in four patients, employing Avidin-Biotin complex methodology (Biomedia Corporation). Appropriate controls were utilized. The identification of a distinct granular pattern constituted a positive staining reaction regardless of the intensity and extent of the staining reaction within the neoplastic tissue.

Results

Four of the five bladder biopsies were read by the pathologists as transitional cell carcinomas of the bladder after the initial histopathologic examination. One patient had a moderately well-differentiated adenocarcinoma invading the bladder and so was not confused as primary bladder tumor. After the tissue from the prostate was submitted, the reports were changed in all patients

and the bladder tumors were considered as extensions of the prostatic cancer.

Table 1 shows the results of immunohistochemical staining for PSAP and PSA.

Comment

We have previously reported the difficulties involved in the diagnosis of rectal obstruction secondary to carcinoma of the prostate.[1] The two cases presented here demonstrate the difficulty involved in discriminating a primary urothelial bladder carcinoma from an undifferentiated prostatic cancer invading the bladder. Ford and associates[2] reported 21 patients with neoplasms of the base and neck of the bladder, which could not be categorized as prostate or urothelial in origin by the conventional means. Immunocytochemical localization using PSA staining showed 11 patients to be of prostatic origin. One of their patients with focal and only faintly positive PSA staining had radiotherapy followed by radical cystoprostatectomy because it was thought to be a primary bladder tumor. Subsequent examination of the surgical specimen confirmed that this indeed was a tumor of prostatic origin. The specificity of PSA staining was reported to be 94% to 97%. The intensity of staining was directly proportional to the differentiation of the tumor.

Adnani[4] also reported the difficulty in diagnosing the origin of carcinomas causing bladder neck obstruction and advocated the use of immunohistochemical staining using PSAP, PSA, and epithelial membrane antigen (EMA) keratin in ascertaining the true origin of the tumor.

In general, immunostaining with PSAP and PSA have been specific for prostatic tissue, but exceptions have been found. PSAP may be positive in renal cell carcinoma, pancreatic islet cell tumors, carcinoids, breast-carcinomas and some bladder adenocarcinomas.[5] False-negative results for both of the markers are not infrequent.[6] In addition, the intensity of staining as well as the degree of positive reaction are affected by the histological grade of the tumor and by hormonal therapy.[7] PSAP immunoreactivity was more commonly positive in our study than PSA staining, but most of our patients had markedly undifferentiated tumors.

If both the urologist and the pathologist keep in mind the possibility of this pitfall, enough discriminating tests are available to diagnose the lesion correctly in every case. In patients with solid and irregular tumors of the bladder neck

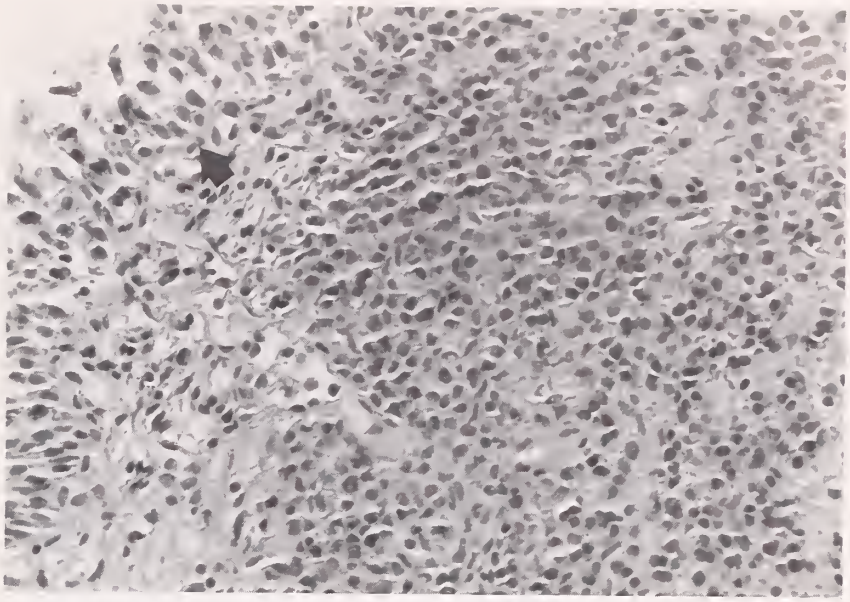

Fig 4 — Urinary bladder biopsy, left lateral wall. Poorly differentiated prostatic carcinomas infiltrating bladder tissues to the basement membrane (arrow) of the overlying urothelium. Hematoxylin-eosin (400X).

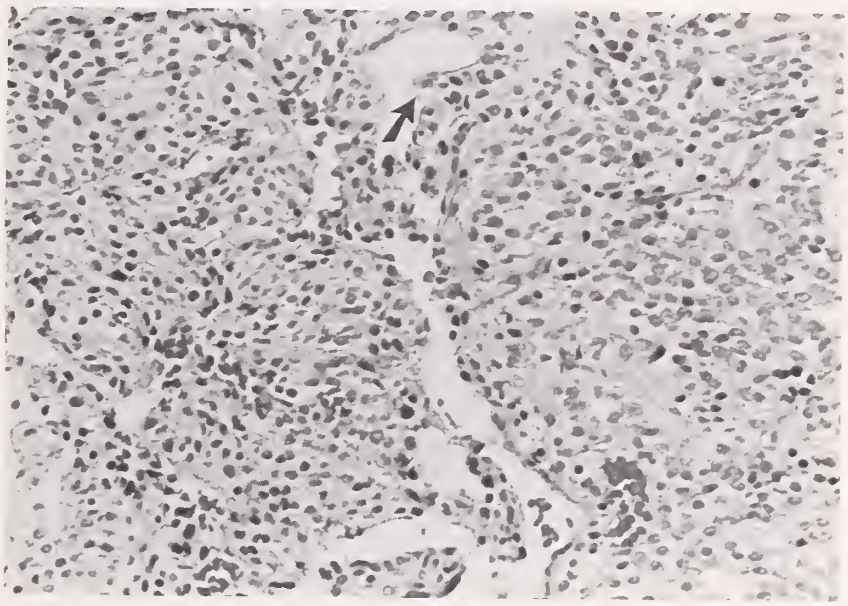

Fig 5 — Prostate, needle biopsy. Rare examples of acinar formation (arrow) were encountered within the primary poorly differentiated carcinoma. Hematoxylin-eosin (400X).

Table 1. Immunohistochemical reactivity for PSAP and PSA in biopsies of lesions from bladder and prostate

	Urinary Bladder		Prostate	
Case #	PSAP	PSA	PSAP	PSA
1	—	—	+	—
2	+	+	+	+
3	+	—	+	+
4	+	—	+	—

and its base, the possibility of its prostatic origin should be kept in mind. Serum markers, ie, prostatic acid phosphatase and PSA, as well as routine prostatic biopsy with immunohistochemical studies of the tissue from the bladder, should be helpful in differentiating the true origin of the tumor.

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AIDS: Intensive Care Utilization and Outcome

Patricia Lee, MD; Frederick T. Dow, MD;
Cindy G. Bryant, RN, CCRN; Thomas M. Roy, MD

A significant portion of health resource dollars are spent providing intensive care. We examined the immediate outcome of the utilization of medical intensive care for the patient with complications of the acquired immunodeficiency syndrome (AIDS) at the teaching hospital of the University of Louisville. Our experience indicates that utilization of critical care services for the AIDS patient may favorably alter immediate morbidity and mortality.

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Introduction

The medical complications of the acquired immunodeficiency syndrome are frequently significant enough to prompt the primary care physician to utilize the technology and monitoring capabilities of the intensive care unit. The financial burden of critical care technology can be substantial and is justified when its use has a reasonable probability of decreasing the patient's morbidity and/or mortality. The number of AIDS patients requiring large commitments of medical services is increasing annually in the Commonwealth of Kentucky. Accurate estimates of the costs and the efficacy of the medical care for AIDS-related complications is essential to allow proper allocation of health resources. In the spirit of promoting effective health care planning, this report analyzes the immediate outcome of medical care provided to the AIDS patient in the intensive care setting of a teaching hospital.

Patients and Methods

Data were available for all patients with AIDS and its complications who were hospitalized at the Humana Hospital University of Louisville from January 1, 1984, through January 31, 1989. Patients were admitted to the ICU at the discretion of the medical house staff and the attending staff based on the need for intensive care and availability of beds. No patients were denied ICU care on the basis of their diagnosis of AIDS.

All patients met the case definition criteria for AIDS as established by the Centers for Disease Control. The following factors were recorded from chart review: (1) the demographic data (age, gender, and race) of the patient; (2) the primary diagnosis at the time of admission to the hospital; (3) the risk factors for acquiring the human immunodeficiency virus (HIV); (4) the need for and duration of intensive care services; (5) the use of mechanical ventilation; (6) the performance of invasive procedures; (7) performance of resuscitative measures; and (8) the outcome of treatment.

For the purpose of this study, survival was defined as ambulatory discharge to home from the hospital.

Results

Seventeen patients accounted for 19 admissions to the intensive care unit. All patients were adult males with a mean age of 36.2 years. The data are displayed in Table 1. Six patients expired in the intensive care unit. Patients, 1, 2, and 12 were resuscitated and intubated emergently in outpatient settings and subsequently admitted to the intensive care unit. Patients 5 and 13 were electively intubated for ventilatory support, but subsequently expired from recurrent *Pneumocystic carinii* pneumonia. Patient 18 decided against intubation, mechanical ventilation, or defribrillation several days after admission to the intensive care unit. He expired without the performance of invasive resuscitation measures. No patient with AIDS in our study group survived aggressive cardiopulmonary resuscitation.

Thirteen of 19 intensive care unit admissions, however, had a positive outcome with the patient eventually leaving the hospital. All survivors returned home for self care.

Discussion

A significant portion of the health care dollar is currently spent providing critical care services and is justified when such intensive care can be reasonably expected to improve morbidity or mortality. Physicians who are asked to provide care for patients suffering the complications of AIDS often wish to utilize the monitoring capabilities and technology available in this setting. With the development of better support groups and more community involvement, the AIDS pa-

Table 1. Intensive Care Utilization for the AIDS Patient

Patient	Age	Sex	Risk Factors For AIDS	Admission Diagnosis	Duration Hospital Stay (Days)	Duration ICU Stay (Days)	Duration of Mechanical Ventilation (Days)	CPR/Code Performed	Survived
1. T.H.	28	M	Homosexual	Coma-Etiology Undetermined	9	4	4	—	—
2. C.R.	42	M	Homosexual	Sepsis/Diarrhea	1	1	1	+	—
3. D.S.	28	M	Heterosexual Transmission IV Drugs	Drug Overdose	4	1	1	—	+
4. B.C.	36	M	Homosexual	Pneumonia-Pneumocystis	25	10	6	—	+
5. R.C.	27	M	Homosexual	Pneumonia-Pneumocystis*	5	5	5	+	—
6. R.W.	35	M	Homosexual	Drug Overdose	4	2	2	—	+
7. W.H.	29	M	Homosexual	Pneumonia-Pneumocystis	44	35	20	—	+
8. R.C.	25	M	Homosexual	Pneumonia-Pneumocystis	27	16	11	—	+
9. H.H.	55	M		Pneumonia-Pneumocystis	11	6	0	—	+
10. R.M.	42	M	Homosexual	Drug Overdose	6	3	2	—	+
11. J.D.	39	M	Homosexual	Pneumonia-Bacterial	6	2	1	—	+
12. J.O.	39	M	Homosexual	Sepsis/Shock	1	1	1	+	—
13. T.D.	28	M	Homosexual	Pneumonia-Pneumocystis*	17	12	12	+	—
14. K.S.	39	M	IV Drug Use	Upper GI Bleed	13	2	0	—	+
15. D.S.	44	M	Transfusion	Pneumonia-Bacterial	13	6	5	—	+
16. D.S.	44	M	Transfusion	Congestive Heart Failure	9	5	0	—	+
17. S.L.	37	M	Homosexual	Pneumonia-Pneumocystis	22	14	14	—	+
18. D.W.	61	M	Homosexual	Hemoptysis	5	5	0	—	—
19. G.R.	34	M	Homosexual	Pleural Effusion Adenocarcinoma	29	8	4	—	+

*Represents recurrence of *Pneumocystis carinii* pneumonia

tient may receive more care in the comfort of familiar outpatient surroundings. The success of these programs suggests that the AIDS patient will be sicker and more likely to require ICU care when eventually admitted to the hospital. In order to provide the appropriate allocation of financial and manpower support, health care planners need an accurate estimation of the utilization of critical care facilities as well as an indication as to whether such intensive care unit admissions reduce morbidity or mortality.

As physicians who see a relatively small number of patients with AIDS, we must often depend on the medical centers located in areas where AIDS is epidemic for the information needed for medical decision making. This early collective medical experience suggested that intensive care would not alter the outcome of this ultimately incurable and fatal disease. More specifically, the use of intubation and mechanical ventilation was discouraged.[1,2] Recent information suggests that this pessimistic outlook be reevaluated.[3,4]

Our experience indicates that AIDS patients with the complications of gastrointestinal bleeding, bacterial pneumonia, cardiogenic pulmonary edema, and drug overdose benefit from intensive care services. Likewise, at our center, the AIDS patient requiring mechanical ventilatory support for respiratory insufficiency secondary to a first time infection with *Pneumocystis carinii* have a reasonable expectation for survival. Equally important, however, respiratory failure from recurrance of *P. carinii* pneumonia in our series was uniformly fatal.

Cardiopulmonary resuscitation in patients with AIDS has been reported to be immediately successful 25% of time, but the survivors who are then transferred to the intensive care unit usually succumb to the disease and only 2.3% leave the hospital alive.[5] Our experience confirms this dismal outlook. None of the AIDS patients in the ICU setting who received aggressive cardiopulmonary resuscitation had a successful outcome.

Our policy regarding intensive care utilization has been to provide these services to fully informed patients if they so desire. Obviously, proper utilization of critical care services will then hinge on giving these individuals the most up-to-

date factual knowledge about the expected benefits of ICU intervention.[6] If at all possible, the subject of life support should be addressed before the need arises so that the patient may document his/her wishes by a living will or by provision of a durable power of attorney for health care. The decision to forego ICU care must not preclude those measures that are necessary to reverse what is reversible and to provide comfort. If intensive care is declined, the fear of abandonment should be addressed by support groups and physicians providing the information for informed consent.

In summary, we surveyed the utilization and outcome of ICU services by the AIDS patient over the last five years in an attempt to provide a basis for health care planning. It is important to allocate the necessary resources and financial support to make critical care available to the AIDS patient when indicated. Presently it appears that certain complications of this devastating illness are better treated in the intensive care unit. Whether the AIDS patients with an irreversible and incurable disease wishes to be treated with potential life support measures to obtain short term benefits may be influenced by proper informed consent[7] which is based on the physician's personal experience and the collective information provided by other medical centers.

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Maxillofacial Trauma

Edward A. Luce, MD; Henry C. Vasconez, MD; A. Byron Young, MD

If a multiply injured patient with severe head injuries, intra-abdominal and intrathoracic injuries is admitted, the diagnosis and management of the facial fractures may be shunted into the background. With the tremendous methods of modern medicine at hand, we are adequately able to resuscitate, treat, and discharge those patients. If the maxillofacial injuries go undiagnosed or untreated, the patient is left with some fairly significant sequelae in function and appearance that are difficult to treat on a delayed basis. Initial management of those injuries can be done concomitantly with management of the other serious life-threatening injuries and a successful outcome achieved.

The traditional approach of waiting "until all the swelling goes down" before definitive correction of bony or soft tissue problems are addressed, has been shown to produce inadequate and disabling results both from a structural and functional viewpoint. Following the first or at most second week after injury, the process of bone healing and scar formation have usually progressed quite quickly. This is especially true in children who normally have a very high metabolic rate. A displaced facial fracture not corrected during the initial "golden" period will require major manipulation and even refracture in order to adequately reduce the segments into the proper position and a less satisfactory result than acute management. Similar considerations with respect to the skin and soft tissues are also important. Once scar tissue has formed it becomes very difficult to restore normal or near-normal appearance. A sunken eyeball, a retracted lower eyelid, a depressed cheekbone, a deviated nose are a few of the potentially preventable late deformities that will challenge even the most expert reconstructive surgeons. Many deformities will occur in cases of severe trauma even when early and adequate treatment is provided. However, with the advent of newer diagnostic modalities, improved surgical techniques, better anesthesia, and a more comprehensive team approach to trauma management, we are now in a better position to treat these severely injured patients early and definitively.

From the Division of Plastic Surgery (Drs Luce and Vasconez) and the Department of Surgery, Division of Neurosurgery (Dr Young), University of Kentucky Medical Center, 800 Rose St, Lexington, KY 40536.

Dr Young: *The topic that we have selected for discussion for Grand Rounds is the management of maxillofacial fractures. The discussant is Dr Ed Luce, Chairman of the Division of Plastic Surgery at the University of Kentucky. Would you begin by discussing the epidemiology of maxillofacial fractures?*

Dr Luce: Approximately 40% of the victims of serious traffic accidents sustain some form of maxillofacial injury and perhaps as many as one-half of those are significant.

Dr Young: *What are the first steps in the management of the airway?*

Dr Luce: The first step is the general airway management of all trauma patients, but I will emphasize problems that can occur with maxillofacial trauma. The first step is to ascertain if the airway can be restored with suctioning of obstruction secondary to blood, debris, broken teeth, and other material in the posterior pharynx. One problem that does occur, but uncommonly, yet requires a prompt diagnosis and treatment is a fractured larynx (Fig 1). A direct impact force to the

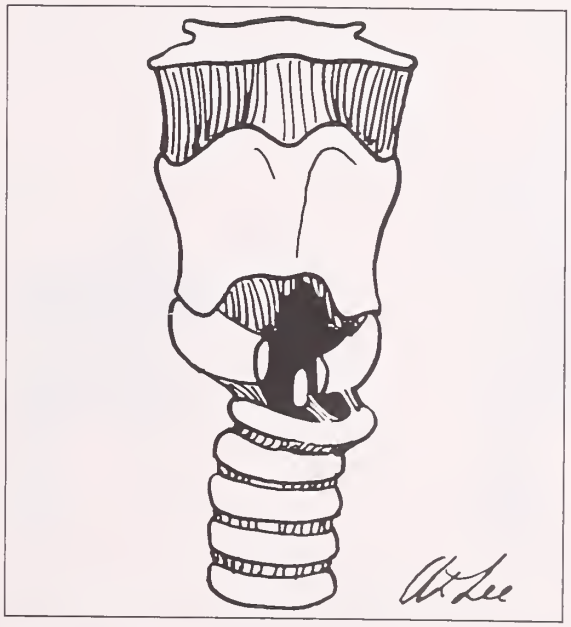


Fig 1

front of the anterior neck can fracture the larynx. The important diagnostic features of a fractured larynx is an injured patient who is profoundly hoarse. In addition, if the injury has involved the hypopharynx, the patient may have dysphagia, or difficulty and pain with swallowing. In some cases the dysphagia may be sufficiently severe that the patient will actually drool rather than swallow their secretions because of the pain. Impending airway obstruction may be signaled by the presence of stridorous respirations. One additional physical finding of value is the loss of the normal thyroid prominence. The thyroid prominence, the "Adams Apple," is more prominent in males than in females. In patients who have sustained a fracture to the larynx, particularly if the fracture involves this thyroid cartilage, the prominence will be lost. The fractures of the cartilage may be palpable on examination of the neck. In addition, if a tear exists in the hypopharynx, the leakage of air into the soft tissues of the neck will create palpable crepitus due to the subcutaneous emphysema. The diagnosis of a fractured larynx is important to make as quickly as possible because those patients can lose their airway rapidly in the emergency room and require prompt treatment. There are a variety of ways to treat and restore the airway in a patient with a fractured larynx but, from my perspective, the safest and most conservative approach is a tracheostomy.

Dr Young: *Bleeding in the mouth is often a problem associated with facial fractures. How frequently is this a significant problem and how do you manage it?*

Dr Luce: Bleeding certainly is a frequent occurrence in patients with maxillofacial trauma, yet most patients with bleeding due to maxillofacial fractures can be managed with anterior packing of the nasal cavity. In more than one-half of the cases, control can be obtained with such nasal packing. If anterior packing is not adequate and bleeding continues in the oral pharynx and posterior pharynx, the steps are to remove the anterior nasal packing, pass a small rubber catheter through the nose into the mouth into the posterior pharynx, secure a gauze packing to the catheter, and withdraw the catheter out through the nose. The pack becomes wedged into the posterior pharynx. An additional string should be attached to the other end of the pack for perioral removal of the pack when necessary (Fig 2A-C). Not infrequently two packs, with one through each nostril, are required. If the patient continues to bleed, a laceration of the internal maxillary artery is the likely cause. The internal maxillary artery is a terminal branch of the external carotid and may be lacerated at the posterior wall of the maxilla (Fig 3A). Since the artery is of substantial size, measures that we have described to this point will not provide adequate control of bleeding and a consultation is required at this juncture. These patients are best managed with direct packing through the maxillary sinus by means of an antrostomy in the labial sulcus (Fig 3B,C). Antrostomy is relatively easy to perform since the maxilla is usually badly fractured. The artery can be packed through the posterior wall of the sinus against the base of the skull (Fig 3D).

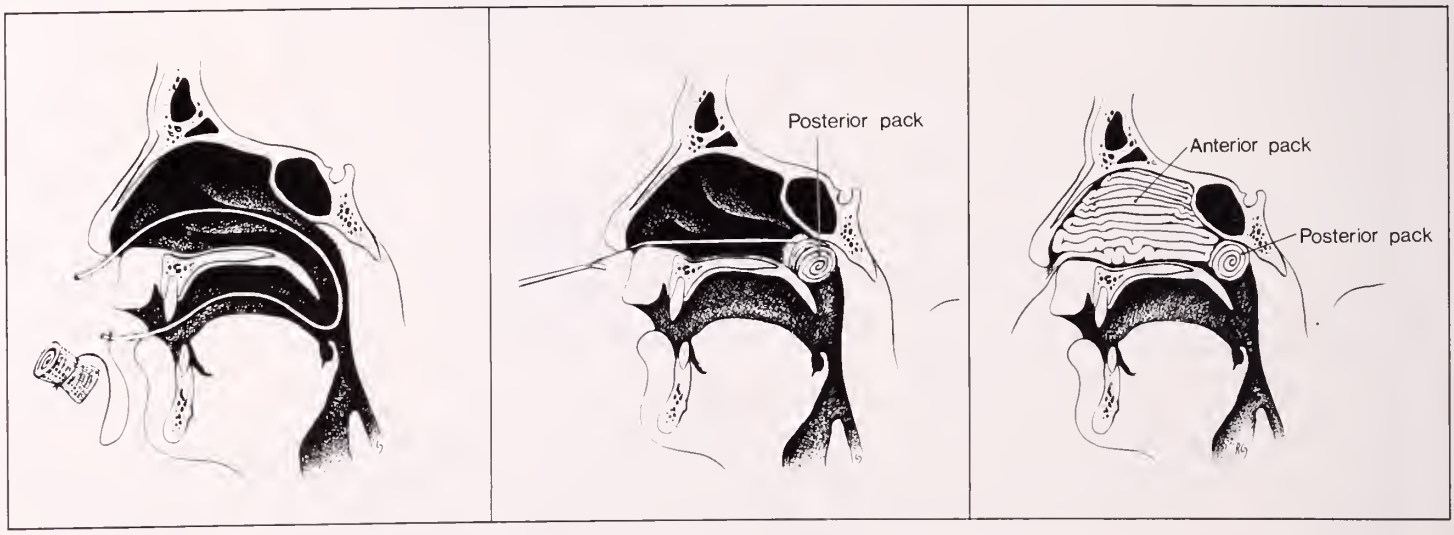


Fig 2-A *Fig 2-B* *Fig 2-C*

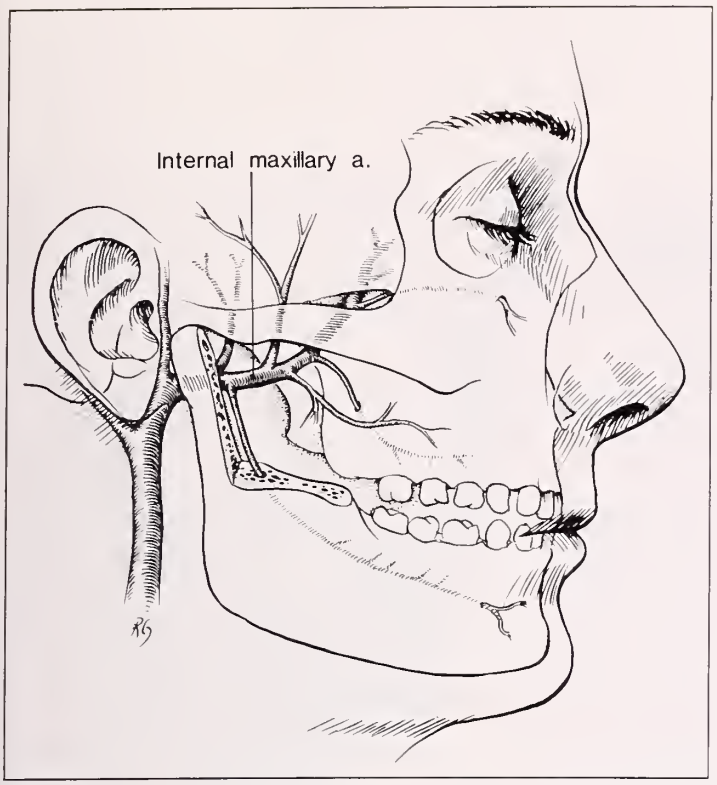
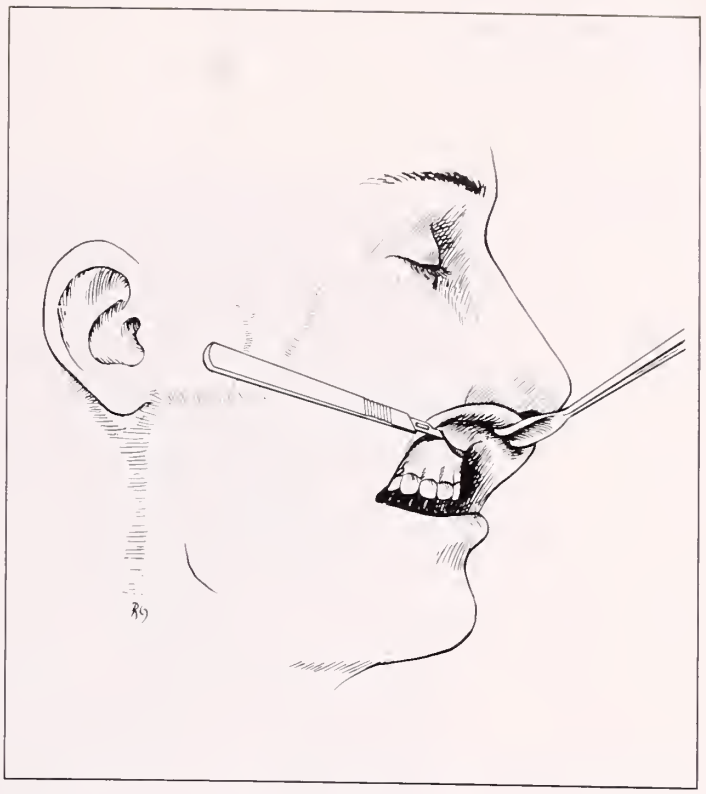


Fig 3-A



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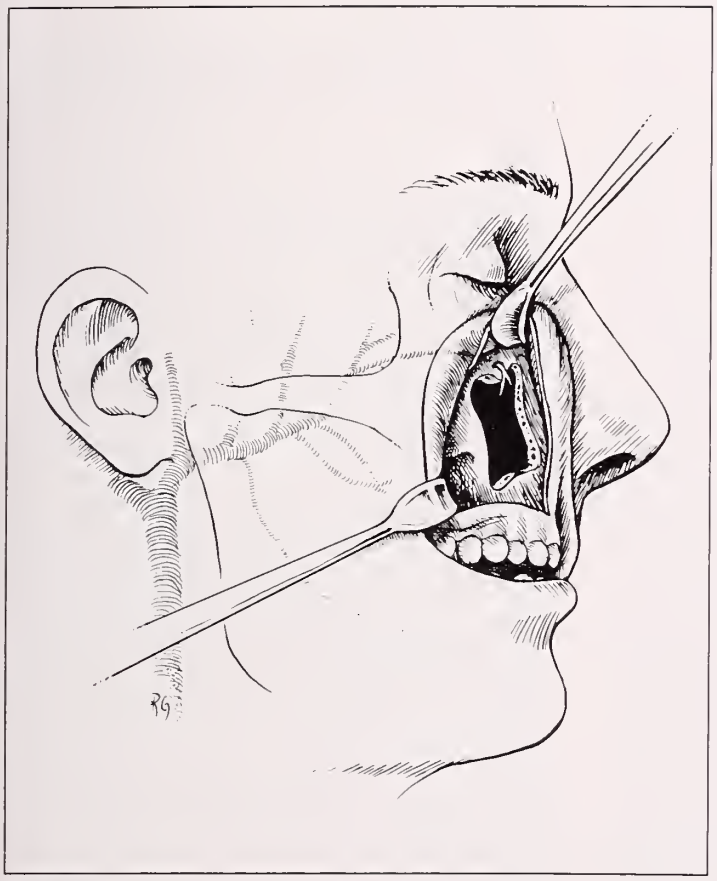

Fig 3-C

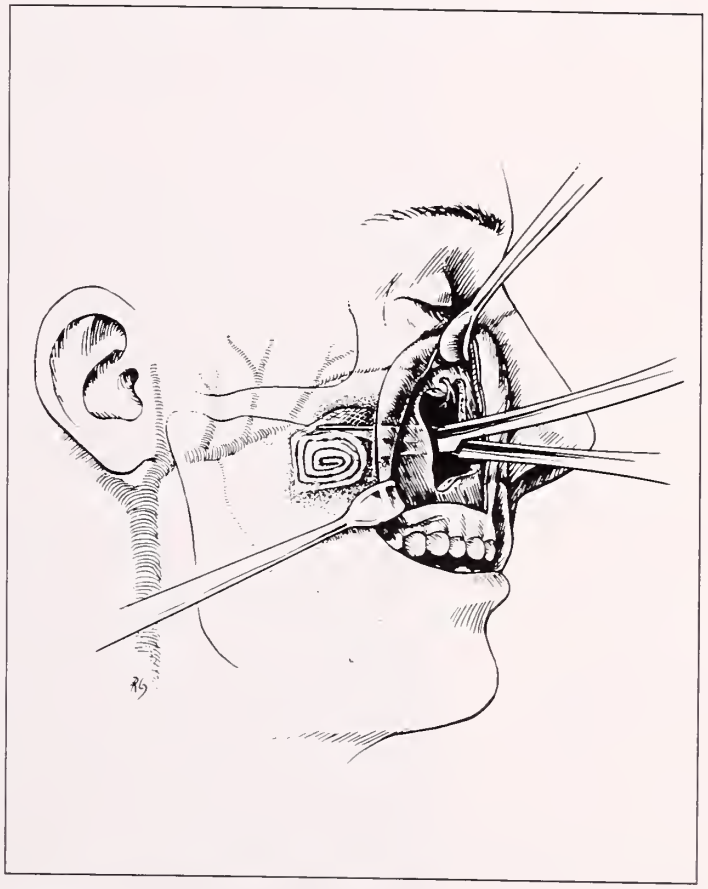

Fig 3-D

Dr Young: *Is an oral tube or a nasal tube more satisfactory to establish the airway in patients with facial fractures? Is the active bleeding an indication for intubation?*

Dr Luce: A couple of factors should be considered. One is, of course, whether the cervical spines are negative, and the other is the presence of complex maxillary fractures. In the presence of complex maxillary fractures, passage of an endotracheal or nasogastric tube through the nasal cavity is contraindicated because of the danger of passage of the tube through a basilar skull fracture into the cranial compartment. In the absence of bleeding, a cervical spine fracture, or a complex maxillary fracture, we would prefer nasotracheal intubation. Bilateral mandibular fractures can produce airway obstruction, particularly in the elderly patient. With bilateral anterior body fractures, the anterior support of the base of the tongue is displaced such that the tongue falls posteriorly and obstructs the airway (Fig 4). The airway can be readily restored with a nasal trumpet and anterior traction on tongue.

Dr Young: *If anterior and posterior packs are placed, is intubation necessary?*

Dr Luce: The decision would hinge on the condition of the patient. The placement of anterior and posterior packs does create an obligatory mouth-breathing situation for the patient, and if other complications exist such as an obtunded status from a head injury, intrathoracic injuries, or other evidence of pulmonary compromise, then the establishment of the airway by intubation would be the most expeditious treatment plan.

Dr Young: *So, if the patient is alert or doesn't have any definite airway problem then packs alone would not dictate any additional airway support?*

Dr Luce: No, they should be able to maintain their own airway.

Dr Young: *What are some of the indications for a request to the ophthalmologist for consultation in the management of the patient's facial fractures?*

Dr Luce: The ophthalmologist should be consulted on any patient with a fracture or significant soft tissue injury in the periorbital region. There are a number of occult injuries that need to be ruled out and the person who can best diagnose an injury such as a subluxed lens, vitreous hemorrhage, or sub-retinal hemorrhage would be an ophthalmologist. All of these injuries may occur in the presence of an orbital fracture.

Dr Young: *An associated injury to the parotid or parotid duct has long term implications for the patient. Why would you suspect such an injury and how would you establish the diagnosis?*

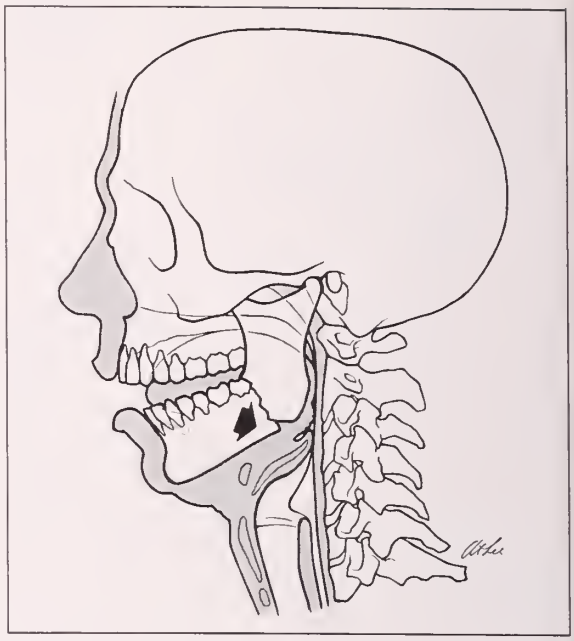

Fig 4

Dr Luce: Knowledge of the topography of the parotid duct is essential to adequate examination and diagnosis of the parotid duct injury. As the duct passes anteriorly toward and into the oral cavity, the most superficial portion is located over the masseter muscle. That portion of the duct can be localized by the central one-third of the line drawn from the tragus of the ear to the philtrum of of the lip (Fig 5). If a patient has sustained a laceration in that region, then we must rule out a concomitant parotid duct injury. The best way to assess integrity of the duct is to cannulate the papilla intraorally. The papilla is located just opposite the second maxillary molar in the buccal cavity. The duct is cannulated with a small polyethylene catheter, and with direct observation of the wound the catheter is gently irrigated with several cc of saline. Extravasation of the saline through the laceration establishes the diagnosis of a parotid duct laceration. I advise against the use of methylene blue or any type of dye. If the duct is injured, all tissues will be stained with methylene blue and identification and repair is more difficult.

Dr Young: *How are facial nerve injuries diagnosed? These patients have considerable fa-*

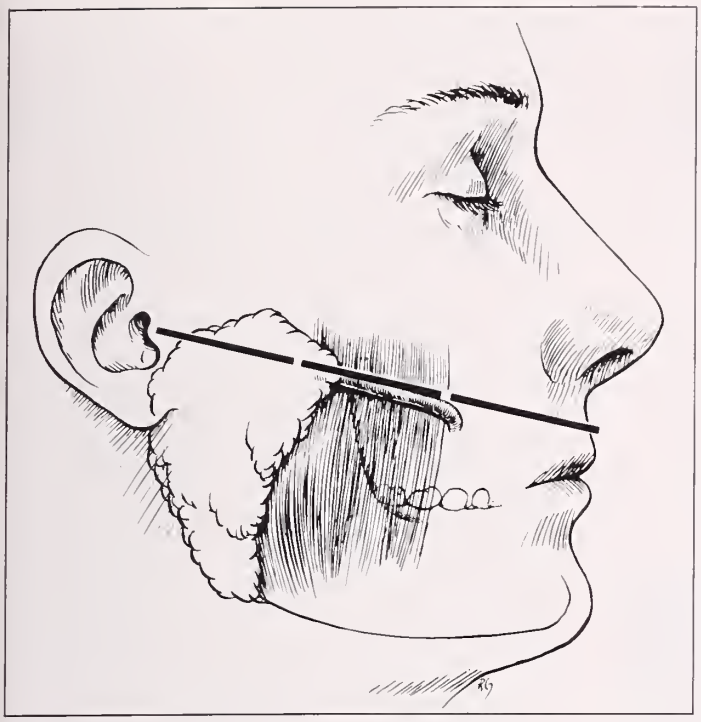

Fig 5

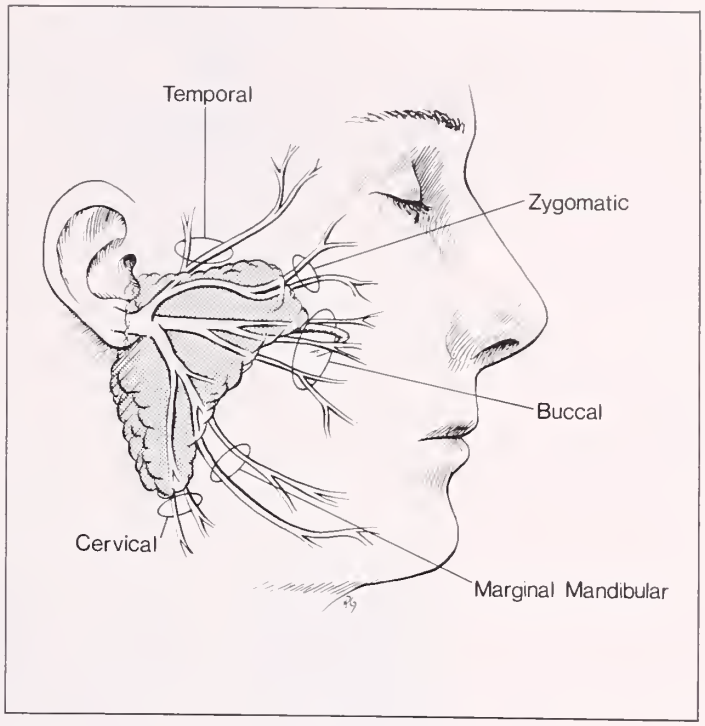

Fig 6

cial edema that creates facial asymmetry. Facial movements may be limited because of the injury so how do you establish the diagnosis with these handicaps?

Dr Luce: Knowledge of the anatomy of the facial nerve and the five branches once it exits from the stylomastoid foramen and courses through the parotid is mandatory (Fig 6). We should also be aware that the young patient who has sustained a complete laceration of the facial nerve will appear normal in repose. Only with facial animation will the asymmetry be evident to the examiner. The patient, if possible, is examined by observation of the voluntary movement of the individual branches of the nerve. That examination consists of elevation of the eyebrow, closing the eye tightly, wrinkling the nose, and pursing the lips. Edema and lack of cooperation may make that examination more difficult to perform.

Dr Young: *Patients that have facial fractures often have an associated basilar skull fracture. The facial nerve can be injured as it courses through the temporal bone. The recognition of a facial nerve injury may lead one to the diagnosis of an associated basilar skull fracture particularly in the presence of otorrhea or loss of CSF fluid through the ear. Additionally, the facial nerve function may be lost secondary to a fracture of the temporal bone.*

Dr Luce: I certainly agree with that point. In fact, the timing of the diagnosis is important since the delayed onset of facial nerve dysfunction due to a temporal bone fracture has an entirely different prognosis than immediate and profound facial nerve dysfunction.

Dr Young: *Are there any other soft tissue injuries that we should discuss?*

Dr Luce: We should discuss the lacrimal duct system. The common denominator of all of these soft tissue injuries is the importance of prompt diagnosis. If the diagnosis is missed a complication can ensue. In addition, management and repair is certainly facilitated by a prompt as opposed to a delayed diagnosis.

First we should discuss lacerations that may involve the normal tear duct drainage system of the eye. In particular, we should consider an injury to the inferior canaliculus in the presence of a laceration in the medial one-fourth of the lower

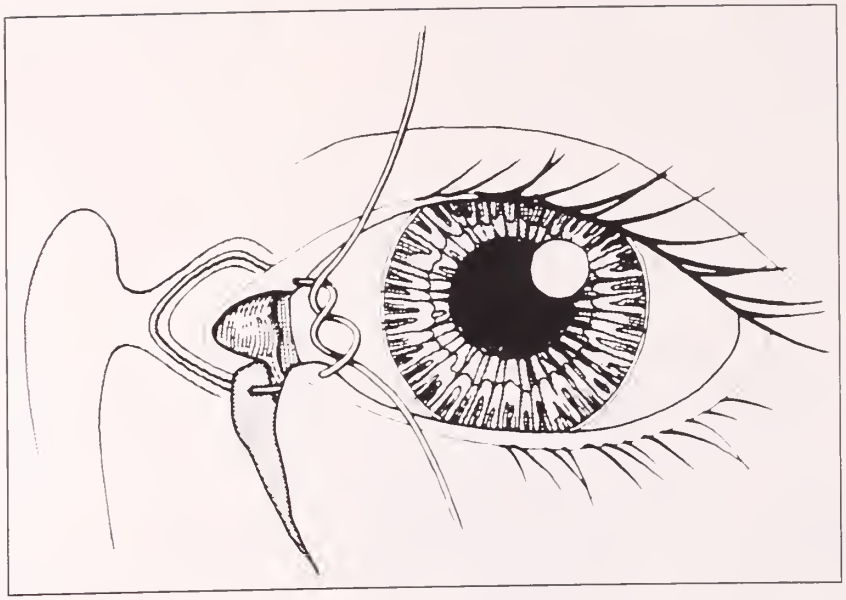

Fig 7

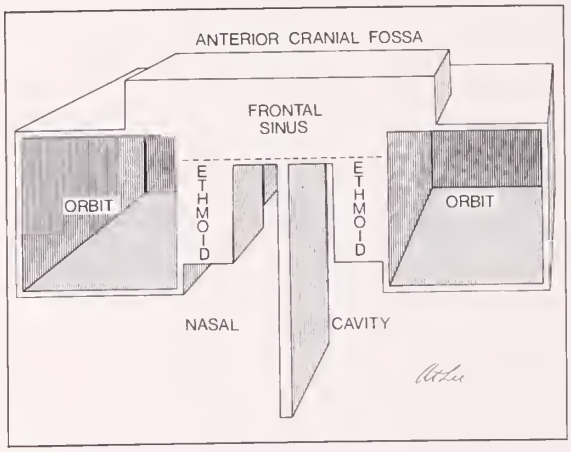

Fig 8

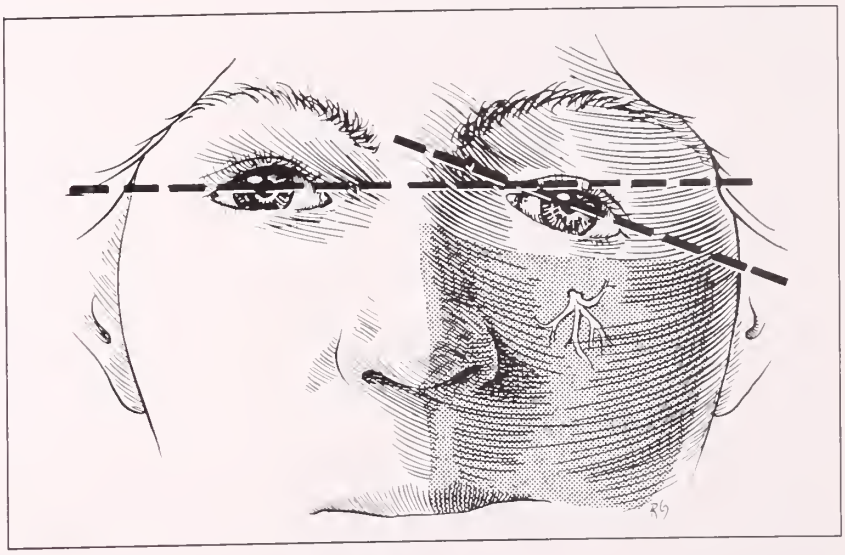

Fig 9

eyelid. That laceration may transect the inferior canaliculus if the laceration crosses the lid margin medial to the punctum or the drainage point for the tears. If so, a fairly simple repair can be accomplished once the diagnosis is made (Fig 7).

Dr Young: *Let's move away from the soft tissue injuries and discuss fractures of the facial skeleton. How do you make the diagnosis of a frontal sinus fracture?*

Dr Luce: A frontal sinus fracture should be suspected in any patient who has a laceration of the forehead, certainly the central one-third of the forehead. Edema in the central forehead region may alert the examiner to the possible presence of an underlying fracture. Plain skull films in the lateral view may detect the presence of a fracture of the anterior wall of the frontal sinus but the diagnostic standard is a CT scan. CT scans are almost always indicated because of the possibility of closed head injury. Detection of a frontal sinus fracture, including the status of the posterior wall and the presence of an air fluid level, is best accomplished with a CT scan.

Dr Young: *Discuss briefly the treatment of frontal sinus fractures.*

Dr Luce: A considerable amount of controversy exists in the area of appropriate management of frontal sinus fractures, particularly the operative indications versus conservative management. General agreement exists that the open frontal sinus fracture, which may be contaminated with road dirt and other debris, should be managed in an operative fashion by irrigation, debridement and repair of the fracture. The fracture of the posterior wall raises a substantial concern about an associated intercranial injury as well as contamination of the intracranial space.

Dr Young: *What are the complications of frontal sinus fractures?*

Dr Luce: The short term complications are related to the important location of the sinus directly anterior to the anterior cranial fossa and above the ethmoid air cells (Fig 8). Since the sinus is a paranasal structure, colonization with bacterial organisms can easily occur in the presence of injury. Contamination of the intracranial space can lead to the complication of meningitis and epidural abscess. In addition, there is substantial concern about late infectious complications related to the sinus such as mucopyocoele.

Dr Young: *I assume you treat open fractures as soon as possible. When should closed fractures of the frontal sinus be repaired?*

Dr Luce: With the exception of undisplaced anterior wall fractures without a fluid collection in the sinus, most other frontal sinus fractures deserve operative management as soon as the patient is stable from a neurosurgical standpoint and from the standpoint of other injuries.

Dr Young: *Zygomatic fractures are among the more common facial fractures. How do you make the diagnosis of a zygomatic fracture?*

Dr Luce: A number of features may suggest the presence of a zygomatic fracture. First, the presence of periorbital ecchymosis should alert the clinician to the possibility of a fractured zygoma. Second, with displacement of the zygoma, flattening of the cheekbone may exist as well as an inferior displacement of the lateral canthus or an anti-mongoloid slant. Third, the patient may have loss of sensation in the upper lip, teeth, and cheek secondary to the injury of the infraorbital nerve (Fig 9). Fourth, the patient may have ocular complaints of double vision and difficulty in looking upward because of involvement of the orbital floor. All of these findings represent the clinical features of a zygomatic fracture.

Dr Young: *What are some of the clinical findings of a patient with a suspected maxillary fracture?*

Dr Luce: Probably the best immediate physical finding is mobility of maxilla on manipulation. The maxilla is a stable structure and any mobility represents an abnormal finding. With thumb and index finger on the maxillary incisors and the other hand on the bridge of the nose, the maxilla is manipulated. Any movement represents a fracture and the palpating hand may detect the level of the fracture indicative of the particular type of maxillary injury.

Dr Young: *What are the indicated radiological examinations in patients with zygomatic and/or maxillary fractures?*

Dr Luce: The baseline radiological examination is the Water's view as well as an anterior-posterior skull film and a submental vertex view. The CT scan has gradually replaced routine facial films for examination of the patient with suspected facial fractures. If the patient has an uncomplicated diagnosed zygomatic fracture, a CT scan is not indicated. More complex maxillary and zygomatic fractures are better delineated with a CT scan. However, these patients have multiple injuries and often have sustained head trauma in addition to their maxillofacial trauma. To expedite management, since the patient may well require a CT scan of the head, the face can be scanned as well.

Dr Young: *May I make a point from a neurosurgical perspective?*

The CT scan of the head should include the face in a patient who has sustained a severe head injury because facial fractures are often associated. However, if the patient's neurologic status is deteriorating, or if the CT scan shows a mass lesion, we should proceed straight to the operating room and not consume valuable time unwisely by adding facial CT scans. In the absence of a deteriorating situation or a mass lesion, the patient's facial bones can be scanned simultaneously rather than at a later date.

Let's briefly discuss mandibular fractures. How do you make the initial diagnosis and what are the initial films that you order?

Dr Luce: The presence of edema and ecchymosis in the lower one-third of the face is suggestive of a mandibular injury. One of the useful tip-offs to the presence of a mandibular fracture is malocclusion perceived by the patient. The first step is to ask the patient to put the teeth together and ascertain if the bite is normal. There is a wide variety of patterns of occlusion and the patient's feedback is important. Another step is to palpate and manipulate the body of the mandible to detect abnormal mobility suggestive of a fracture. A careful intraoral examination for fractured teeth and a laceration of the alveolar ridge may also reveal a mandibular fracture. Patients with fractures of the condyle will have pain in the immediate preauricular region and examination of the condyle and the temporomandibular joint is facilitated by placement of the examiner's index finger into the external auditory canal while the patient goes through various masticatory movements. My baseline requests for x-rays are an AP, lateral and oblique views of the mandible, a Town's view for the condyle, and a panorex if a mandibular fracture is seen on the initial films.

Dr Young: *Facial fractures are often misdiagnosed and undertreated. Dr Henry Vasconez, Assistant Professor of Plastic Surgery, will sum up by outlining some of the complications and sequelae of missed facial fractures and inadequate treatment.*

Dr Vasconez: If a multiply injured patient with severe head injuries, intraabdominal and intrathoracic injuries is admitted, the diagnosis and management of the facial fractures may be shunted into the background. With the tremendous methods of modern medicine at hand, we are adequately able to resuscitate, treat, and discharge

those patients. If the maxillofacial injuries go undiagnosed or untreated, the patient is left with some fairly significant sequelae in function and appearance that are difficult to treat on a delayed basis. Initial management of those injuries can be done concomitantly with management of the other serious life-threatening injuries and a successful outcome achieved.

The traditional approach of waiting "until all the swelling goes down" before definitive correction of bony or soft tissue problems are addressed, has been shown to produce inadequate and disabling results both from a structural and functional viewpoint. Following the first or at most second week after injury, the process of bone healing and scar formation have usually progressed quite quickly. This is especially true in children who normally have a very high metabolic rate. A displaced facial fracture not corrected during the initial "golden" period will require major manipulation and even refracture in order to adequately reduce the segments into the proper position and a less satisfactory result than acute management. Similar considerations with respect to the skin and the soft tissues are also important. Once scar tissue has formed it becomes very difficult to restore normal or near-normal appearance. A sunken eyeball, a retracted lower eyelid, a depressed cheekbone, a deviated nose are a few of the potentially preventable late deformities that will challenge even the most expert reconstructive surgeons. Many deformities will occur in cases of severe trauma even when early and adequate treatment is provided. However, with the advent of newer diagnostic modalities, improved surgical techniques, better anesthesia, and a more comprehensive team approach to trauma management, we are now in a better position to treat these severely injured patients early and definitively.

Memoir of David L. Stewart 1923-1989

by Paul C. Grider, MD

David Stewart died in November. He lived the last weeks of his life with the same enthusiasm and verve which had characterized his preceding 60-odd years. He finally succumbed to his disease, but he was never ill with it. It was in him, but he was not of it.

This was not the first time he had faced death. As a young missionary in Africa, he developed a cancer which he thought would take him. To his surprise, he was operated and cured.

He faced death a second time with his first wife's illness. He lost the battle, but never cringed or lost his courage, wit, or determination in the face of the inevitable for his loved one.

These brushes with death may have had something to do with his excellence as a physician.

He was as good a clinician as I've ever seen. But more than that, he conveyed that intangible attribute of really caring what happened to the patient. This was readily sensed and appreciated by those for whom he cared.

And finally, he cared not only for the patient but also for his fellow physicians — most particularly, those who had lost their way. He was gentle yet stern, understanding yet demanding in his approach to their particular failing.

He has left us with a role model of excellence as a person, husband, father, physician that few of us will match. Those of us who knew him will always be in his debt.

Dr Stewart served KMA as chairman of the Impaired Physicians Committee and as an assistant editor of the Journal. His contributions were invaluable, and he will be missed.

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Differentiated Carcinoma of the Thyroid

THE proper treatment of well differentiated (papillary and follicular) carcinoma of the thyroid is not well established. There are great differences of opinion among the experts. There is a great disparity in reported incidences of recurrence and mortality. This is a malignancy which is relatively rare. It has a great tendency to metastasize to cervical lymph nodes. Despite this fact, the prognosis is excellent and death caused by it is unusual. The prognosis for cure is better for patients younger than 40 than for patients older than 40. Females do a little better than males.

The usual presentation is a solitary nodule in one lobe of the thyroid. The decision for or against surgical intervention is based on various factors among which are some or all of the following:

1. physical findings
2. radioisotope scans
3. needle aspiration or needle biopsy
4. ultrasound studies

At surgery the involved lobe and isthmus are usually removed. If frozen section reveals well differentiated carcinoma, a variety of treatment options are available, each of which has authoritative proponents. They are (assuming the other lobe is grossly normal):

1. Do nothing more other than local excision of any grossly abnormal lymph nodes in the area
2. Removal of most of the opposite lobe and grossly abnormal nodes
3. Total thyroidectomy and removal of abnormal nodes
4. Total thyroidectomy and ipsilateral modified neck dissection
5. Same as No. 3 or No. 4 plus later ablation of any residual thyroid tissue with radioactive iodine and subsequent repeat body scans with radioactive iodine to identify and treat any distant metastases

In all options thyroid medication is given post op for thyroid replacement and/or suppression of pituitary thyroid stimulating hormone.

Enthusiastic support can be abundantly found in the surgical literature for each of the above options. The choice of treatment by each surgeon is influenced greatly by his residency training. The results of all five options of treatment are excellent and, consequently, everybody is happy with what he is doing.

My own bias is for option No. 1. From what I have seen and read the results of this conservative approach are equally as good as other options and the surgical complications are less. Option No. 5 entails considerably more expense and does not, I think, improve results.

McHenry S. Brewer, MD

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Issues on Which Reasonable People Disagree and Minimum Acceptable Standards

To the Editor:

This is a response to the editorial by Dr Russell L. Travis in the August 1989 issue of the *Journal.*

Referring to the acute-care demonstration this Department sponsored in four local health departments, Dr Travis calls it "misleading" to compare the project's average $42 cost per visit to the average $52 Medicaid paid for primary care center visits in FY 1987-88. He writes, "What the report failed to report was the fact that the average cost per routine visit paid to a private physician's office was $12-$17 for the same period."

Dr Travis implies that the $42 paid to the health departments, the $52 paid to primary care centers, and the $12-$17 paid to physician offices are all buying the same thing. Of course, that's not true. The primary care center and health department visit costs are higher, because the visits include *both* physician care *and* other services.

Moreover, Dr Travis understated the private office costs. Medicaid pays $11-$20 for a routine private office "visit" alone. If any "procedures" are performed (tests, etc), each procedure is separately reimbursed, at an average of $15-$16 per procedure. Thus a routine office visit involving two or more procedures could cost more than the average health department visit did.

It is not true, as Dr Travis states, the patients received no drugs. Up to 5% of the project's budget could be spent on drugs. The project also provided or arranged for discounted X-ray and laboratory services not mentioned by Dr Travis.

It is true that the project did not pay for hospitalization, but (contrary to Dr Travis's assertion) neither do primary care centers or the KenPAC program for $52 a visit (or per month, the editorial is unclear on this assertion). Project staff successfully obtained specialty and hospital care for every patient who needed it.

The most objectionable content in the editorial is the insinuation that these patients did not receive care meeting "minimum acceptable standards." This implication, which pervades the article from title to end, is an insult both to the private physicians and to the department nurses who cared for these indigent patients.

Health department nurses are required to meet the most stringent standards in the state. As to the quality of the acute medical care provided by the project's contract physicians, surely Dr Travis did not intend to derogate this.

The real debate here is whether to hold out for a comprehensive indigent health care program that is unlikely to be funded anytime soon, or to cooperate in a partial solution that has already proven its effectiveness. The difference in annual cost is about $6 million versus $200-$250 million.

C. Hernandez, MD, MPH
Commissioner
Department for Health Services

The above letter was referred to the author of the editorial in question, and his reply follows:

To the Editor:

Dr Hernandez reinforces the point I made about costs of providing primary care services in health departments. Costs are higher in the health departments because visits include both physician care *and* other services. Those costs include fixed overhead expenses of all services available at health departments and are factored into charges.

Regarding drug coverage, the project's report states that pharmaceutical products were obtained from "drug samples provided free by pharmaceutical companies" . . . and "local pharmacies willing to provide discounts, and in some cases, the departments paid directly for essential drugs." It is one thing to obtain free samples for limited pilot programs, but something else to rely on an unstable source for the entire state's noninsurance covered indigent population. This is a lesson we've learned from the Kentucky Physicians Care program. Thus, it is reasonable to believe that the departments' cost of including needed drugs, if Dr Hernandez's program was implemented, would exceed the $42 per visit quoted.

Hospitalization is a significant cost in the indigent care equation, but was not included in the Health Department's plan as a covered service. It is unrealistic to address the medical needs of the indigent without providing a comprehensive hospital plan.

There was never any intent to insinuate that patients seen through this project received care which didn't meet "minimum acceptable standards." I simply stated my opinion that "the medically indigent deserve at least the basic services provided solely by licensed physicians. Anything less should be unacceptable to us as guardians of the health care of the medically less fortunate."

I firmly believe that health departments cannot contract with local physicians to provide care in existing health department facilities less expensively than those presently provided in physicians' offices. Quality of care provided in the pilot program was never an issue.

As previously stated, health departments play a meaningful role and their traditional functions in areas of sanitation, maternal and child health and epidemiology are appropriate. At issue is the appropriateness of expanding government's role into delivery of primary care in direct competition with the private practitioners.

Russell L. Travis, MD

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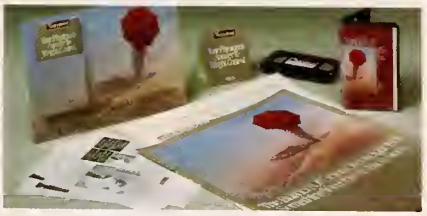

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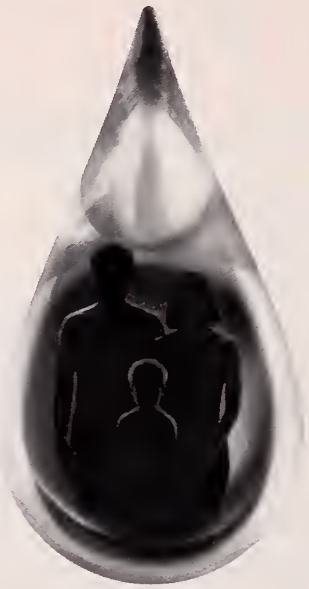

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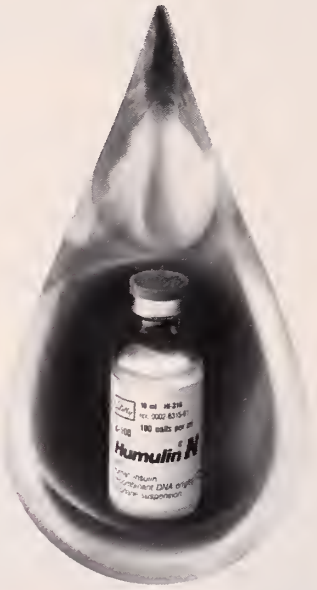

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Are You Included in the Political Process?

'We cannot stress strongly enough the importance of becoming politically active this year. With the General Assembly meeting only every two years, a legislative year becomes that much more important. There are many groups making their voices heard and medicine can no longer "not get involved."'

The AKMA will have another DAY AT THE CAPITOL on February 7, 1990. As you know, this is not just an AKMA function. All spouses and members of KMA are invited to attend. Our day will begin with a briefing by a KMA member representative and Don Chasteen, Director of KMA Public Affairs. They will update us on the progress of certain bills relating to medicine and the stand the KMA takes on these bills. Then there will be time to make contact with individual representatives. During lunch an invited representative will speak. After lunch passes will be available for those who wish to attend a session of the General Assembly.

We cannot stress strongly enough the importance of becoming politically active this year. With the General Assembly meeting only every two years, a legislative year becomes that much more important. There are many groups making their voices heard and medicine can no longer "not get involved." Many laws regulate medical practices today that did not exist 20 or 30 years ago and there are many new regulations under consideration. These issues are so complex that legislatures and the public must be educated.

We in the AKMA are becoming more involved in the political process — from updates by Dr Wally Montgomery and Don Chasteen, and workshops at the Fall Board, to having an organized phone bank that can be used at a day's notice. The AKMA phone bank is centrally located in Fayette County and activated when KMA feels calls to legislators would help. A KMA representative calls the phone coordinator to activate the bank, she then calls volunteers to meet at a central location, and the volunteers place calls to contact physicians who then call their legislator.

We strongly urge all spouses to join KEMPAC & AMPAC. It is time for us to lend our voices to those of the Medical Association and truly make a difference by showing strength in unity.

We in the AKMA are seeing the need to improve the political awareness of our members and spouses, as it will affect all our futures.

'We strongly urge all spouses to join KEMPAC & AMPAC. It is time for us to lend our voices to those of the Medical Association and truly make a difference by showing strength in unity.'

We want to finish with a quote from Dr Nelson Rue, President of the KMA, "We must make a concerted effort to remain a part of the decision-making process before that participation is no longer an option."[1]

Alberta Gerson
Diana Moore
AKMA Legislative Committtee

Reference

1. Rue, Nelson: *Journal of the Kentucky Medical Association*, October, 1989.

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If so, please submit in writing to:

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122 Ridgewood, Pineville 40977
1987, U of Louisville

Boyd

Jennifer G. Collins, MD — FP
25th & Center, Catlettsburg 21129
1986, U of Miami

Boyle

Paul Philip DeLuca, MD — SU
333 S Third St, Danville 40422
1984, U of Kentucky

Fayette

Karen A. Boggess, MD — IM
1221 S Broadway, Lexington 40504
1980, U of Louisville

Barrett B. Bradley, MD — OBG
1235 Eldemere Rd, Lexington 40502
1983, Indiana U

Frank A. Burke, MD — ORS
120 Chinoe Rd, Lexington 40502
1981, Georgetown U

Carol M. George, MD — IM
723 W Cooper Dr, Lexington 40502
1986, U of Kentucky

A. Kinney Hiett, MD — OBG
228 Barberry Ln, Lexington 40503
1985, U of Kentucky

Edward A. Luce, MD — PS
3153 Warrenwood Wynd, Lexington 40502
1965, U of Kentucky

Tamara L. Sanderson, MD — PATH
RR 8, Rice Rd, Lexington 40510
1976, U of North Carolina

Franklin

Laura J. Lord, MD — PD
4 Physicians Park, Frankfort 40601
1986, Medical Col of Georgia

Kenneth E. Marshall, MD — FP
502 W Broadway, Lawrenceburg 40342
1986, U of Kentucky

Leslie F. Stork, MD — FP
King's Dgts Hosp, Frankfort 40601
1980, U of Arkansas

Greenup

Gail D. Feinburg, DO — FP
409 Bluebird Dr, Russell 41169
1984, Pomona Col of Osteopathic Medicine

Howard L. Feinburg, DO — IM
409 Bluebird Dr, Russell 41169
1984, Pomona Col of Osteopathic Medicine

Graves

Dinesh H. Shah, MD — IM
220 W Walnut St, Mayfield 42066
1971, Baroda Medical Col

Hardin

Lynn Margaret A. Keith, MD — GP
602 Transylvania, Elizabethtown 42701
1987, Uniformed Services U

Harlan

Frederick A. Acevedo, MD — PUD
135-A Ivy Hill, Harlan 40831
1982, U of the Philippines

Deborah L. Co, MD — IM
94 Ballpark Rd, Harlan 40831
1984, U of the Philippines

F. Andrew Morfesis, MD — SU
Daniel Boone Clinic, Harlan 40831
1979, Pennsylvania St

Gregory Y. Tiu, MD — R
PO Box 165, Grays Knob 40829
1977, U of the Philippines

Henderson

Gerald R. Rightmyer, MD — FP
110 3rd St, #160, Henderson 42420
1985, U of Kentucky

Jefferson

Richard M. Briggs, MD — TS
330 Audubon Med Pl, Louisville 40217
1978, U of Kentucky

Roger H. Herzig, MD — H
Brown Cancer Ctr, Louisville 40292
1970, Case Western Reserve U

Don A. Stevens, MD — PD
1505 Sylvan Wynd, Louisville 40205
1982, U of Louisville

Katherine A. Witherington, MD — IM
1112 Donard Pk Ave, Louisville 40218
1972, U of Louisville

Livingston

William A. Guyette, MD — R
RR 2, Box 224-D, Burna 42028
1981, U of Texas, Galveston

Madison

G. Irene Minor, MD — FP
PO Box 4010, Berea 40403
1981, U of Kentucky

McCracken

David C. Ginn, MD — IM
150 Quail Run Ct, Paducah 42001
1984, U of Texas, Dallas

Nelson

Hugh Hall, Jr MD — FP
201 S 5th St, Bardstown 40004
1986, Wright St

Pulaski

G. Renee Thomas-Clark, DO — P
1004 Winding Ridge, Somerset 42501
1982, Michigan St, Col of Human Medicine

Rowan

Allen S. Lim, Jr, MD — IM
234 Medical Circle, Morehead 40351
1978, U of the East

Warren

Robert Scott Smith, MD — P
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1969, Medical Col of Virginia

New In-Training

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St. Elizabeth —
Chris Wong, MD — **FP**
Patrick H. Kunkler, MD — **FP**
Timothy S. Reid, MD — **FP**
Susan C. P. Wenk, MD — **FP**

DEATHS

Andrew M. Moore, MD
Lexington
1918-1989

Andrew M. Moore, MD, a retired plastic surgeon, died July 22, 1989. Doctor Moore was a 1943 graduate of Washington University School of Medicine and was a life member of KMA.

James Kelly Hancock, MD
Louisville
1948-1989

James Kelly Hancock, MD, a gastroenterologist, died October 11, 1989. Doctor Hancock was a 1974 graduate of the University of Louisville School of Medicine and a member of KMA.

Denis G. Martin, MD
Prospect
1936-1989

Denis G. Martin, MD, a nephrologist, died October 14, 1989. A 1960 graduate of the University of Dublin in Ireland, Doctor Martin was an active member of KMA.

John Dickinson, MD
Glasgow
1908-1989

John Dickinson, MD, a general surgeon, died October 14, 1989. Doctor Martin was a 1933 graduate of the University of Louisville School of Medicine and was a life member of KMA.

John W. Pate, MD
Madisonville
1925-1989

John W. Pate, MD, an ophthalmologist, died October 18, 1989. A 1952 graduate of the University of Arkansas School of Medicine, Doctor Pate was a life member of KMA.

Michael R. Cronen, MD
Louisville
1907-1989

Michael R. Cronen, MD, a retired internist, died October 21, 1989. Doctor Cronen was a 1941 graduate of the University of Louisville School of Medicine and a life member of KMA.

Daryl P. Harvey, MD
Glasgow
1914-1989

Daryl P. Harvey, MD, a retired general practitioner, died November 16, 1989. A 1943 graduate of Tulane University of Louisiana School of Medicine, Doctor Harvey was a founding partner of the Howard Clinic in Glasgow. He was a member of the Kentucky State Board of Medical Licensure and Kentucky State Board of Health, and was a longtime member of the KMA House of Delegates. Doctor Harvey also served KMA as a member of the Community and Rural Health and School Health Committees. He was a life member of KMA.

Philip Jones Begley, MD
Harlan
1915-1989

Philip J. Begley, MD, a general practitioner, died November 22, 1989. A 1939 graduate of Vanderbilt University School of Medicine, Doctor Begley was a life member of KMA.

Ralph G. Thomas, MD
Leitchfield
1921-1989

Ralph G. Thomas, MD, a retired general surgeon, died in November, 1989. Doctor Thomas was a 1947 graduate of Western Reserve University School of Medicine and was a life member of KMA.

Larry W. Brown, MD
Finchville
1954-1989

Larry W. Brown, MD, a cardiologist, died November 28, 1989. A 1981 graduate of the University of Louisville School of Medicine, Doctor Brown was an active member of KMA.

PEOPLE

Judy Linger, a University of Kentucky College of Medicine student, has been elected to the high office of vice-chair of the Governing Council of the Medical Student Section of the American Medical Association. As a member of the council, Mrs Linger of Georgetown is one of five students from across the nation representing more than 37,000 medical students.

A third-year medical student, Mrs Linger is the first UK student to hold an office on the governing council. The council's primary responsibility is to oversee that policies established by the Medical Student Section and the AMA are followed by students.

"To be selected by your peers to serve in such a prestigious position is one of the greatest honors an individual could receive," **Dr Emery Wilson,** dean of UK's College of Medicine, said. "The fact that a UK College of Medicine student is one of only five students chosen to serve on a council representing so many students is proof that our College consists of the highest caliber of students. Mrs Linger has brought to us a great honor and we are fortunate to have her representing UK on a national level."

According to Mrs Linger, the MSS establishes policies relating to medical students. Issues decided upon by the MSS and the AMA include medical ethics, curricular changes, and educational issues. She described an additional role of the student section as being somewhat the conscience of the AMA.

"We do bring up a lot of ethical issues," she said. "We try to remind people that there are changes that need to be made, not in the way medicine is practiced, but to assure that ideals are upheld when the decisions are made on medical issues."

Present issues the council is concentrating on are tax deductibility status of higher education loans, resident hours, and helping medical schools organize local medical students sections. In addition, the council serves as a liaison to inform medical students of what is occurring on the national level.

The mother of two, Mrs Linger has been in the medical field for more than 10 years. After receiving her undergraduate degree from UK, she began her career in medical technology. Once her youngest child began kindergarten, Mrs Linger enrolled in medical school. Following her first year of medical school, she attended her first AMA national meeting at which time she developed her interest in the Association.

"I came away from that meeting really excited about what was happening on the national level," Mrs Linger said. "I wanted to become more involved so I requested an appointment to a committee. Through this committee, I began meeting people and they eventually approached me to run for office this year."

In addition to her position on the governing council, she is a member of the National Residency Matching Board as an AMA student representative. The board is responsible for matching fourth-year students to residency programs.

With her involvement in community activities, her scholastic and professional activities, and her family, Mrs Linger is aware of the pressures the added responsibility of being vice-chair will bring. However, she knows that with the help of her husband, Doug Linger, a pharmacist in Georgetown, and friends throughout her community, it can be done and will prove very worthwhile.

Dr Hoyt D. Gardner and **Rose B. Gardner** have received the "Irving H. Shaw Distinguished Service Award" from the Kentucky Association of Health Underwriters. The award was given for their activities for medical-services organizations and support of Mission House, a shelter for homeless men in Louisville.

Dr Harold D. Rosenbaum has been appointed by the University of Kentucky Board of Trustees as the first occupant of the Rosenbaum Chair of Diagnostic Radiology in the UK College of Medicine. Dr. Rosenbaum, the first and only chairman of the department of diagnostic radiology, has held that position since 1960.

Established in 1986 in honor of Dr Rosenbaum and his wife Doris M. Rosenbaum, the endowed chair was created entirely from private individual contributions from citizens, patients, departmental faculty, residents, and alumni. Efforts to endow a chair in diagnostic radiology began in 1972 and were the first such efforts at the University. Former residents in diagnostic radiology initiated the endeavor to honor an active department chairman. The purpose of the chair is to nurture a high level of excellence and enrich the academic activities of the department of diagnostic radiology and ultimately the College of Medicine.

"The College of Medicine is grateful to Dr Rosenbaum and his colleagues for establishing this endowed chair," said **Dr Emery A. Wilson,** dean, UK College of Medicine. "As one of the original department chairmen, he has provided valuable leadership to the Department of Diagnostic Radiology and to the College of Medicine."

A native of Fairplay, KY, Dr Rosenbaum received a bachelor of arts degree from Berea College in 1941 and his medical degree from Harvard Medical School in 1944. Prior to his UK appointment, he was in private practice in Lexington.

Dr Rosenbaum has authored numerous publications and textbooks and has lectured extensively. He is recognized for performing the first cardiac catheterization in Kentucky and instituting the first program in the United States to train physician assistants in diagnostic radiology. He was also instrumental in establishing the first Magnetic Resonance Imager in Kentucky in 1984.

The senior clinical faculty member in length of service in the College of Medicine, Dr Rosenbaum is also the senior department chairman of diagnostic radiology in the United States. He has trained more than 100 residents in diagnostic radiology.

UPDATES

ABFP Celebrates 20th Year and Urges FPs to Donate Hours of Medical Care to Poor

A two-day program of events held in Lexington, KY to commemorate the 20th anniversary of the American Board of Family Practice (ABFP) was attended in mid-October by more than 150 of the nation's leading medical educators, clinicians, administrators, and others in the health care industry.

"In 1969, Family Practice, the 20th primary medical specialty in the United States was duly recognized," said **Dr Nicholas J. Pisacano,** a pioneer and founder of the ABFP and

current executive director and secretary.

"From almost nothing in 1969 to the second largest medical specialty in America today, we have made our mark as *the* primary specialty of 'primary care' specialties. We still believe that the grace and hope of Family Practice lie in the striving to keep aflame the magnificent light of medicine by effecting training programs and systems of practice that consecrate us to the common weal."

The ABFP, established as the certifying organization for the specialty, pioneered the mandatory recertification for all its diplomates who wish to maintain that medical status. Recertification involves a lengthy, written examination of cognitive knowledge relevant to Family Practice that is taken every six to seven years.

In 1987, the ABFP and ABIM announced an unprecedented alliance between the nation's two largest medical specialties. In an effort to upgrade the quality of care of the rapidly expanding population of elderly Americans, the two boards joined together to utilize a single high standard for the certification of their diplomates in Geriatric Medicine. Each now issues a Certificate of Added Qualifications to candidates who satisfactorily meet post-residence training requirements and pass an objective examination in Geriatric Medicine. Additional joint efforts are currently underway.

To significantly mark the ABFP's special 20th anniversary occasion, a motion was adopted at a scheduled board meeting which preceded the celebration, to urge all ABFP diplomates to donate, beyond their regular practices, a minimum of four hours a month of hands-on medical care to medically indigent persons. Recognizing that each family physician's situation is unique in terms of time availability, the Board suggests that each assess an effective and methodical way to serve the needy in his/her community.

A special luncheon was attended by more than 60 physicians, 44 of which were founding and past ABFP board members, and later, a gala black-tie dinner was attended by more than 250 guests.

U of L to Teach Doctors Better Business Skills

The University of Louisville is working to remedy the problems faced by many doctors who lack the management and administration skills to run their own businesses.

U of L recently received a three-year, $345,954 grant from the US Health Resources and Services Administration to teach business skills to residents in the Department of Family Practice. Classes will begin in August 1990.

The program is the first of its kind, according to **Dr Richard Blondell,** assistant professor of family practice and principal investigator for the project.

"Doctors are not trained to run an office," he said. "In today's increasingly complex health business world, this type of program is a much needed one. It's like a Cliff's Notes MBA."

Doctors will take courses in accounting, management, and business administration from School of Business faculty members, reported Susan Zurcher, the program's academic coordinator. She said the courses are useful to doctors in all types of practices.

Dr Blondell expects the U of L program to serve as a model for other universities.

For more information, call Dr Blondell at (502) 588-1997.

Shocking Gallstones

University of Louisville physicians are treating gallstones with a shocking new device.

The $1.5 million Sonolith 3000 lithotripter uses shock waves to pulverize the stones into bits small enough to be passed through the body. Doctors use ultrasound to locate the stones and then use electrodes to shoot them with shock waves.

The experimental procedure is an alternative to surgery, and will be used on an outpatient basis once the Food and Drug Administration grants approval.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

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Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

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KMA 140th Annual Meeting

Make plans now to attend!

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Louisville

FEBRUARY

Feb-April — 31st Annual Postgraduate Institute, Baltimore, Maryland. Presented by the Johns Hopkins University School of Medicine. Home Study Course A is provided each registrant for personal reading and microscopic study in their own laboratory in preparation for Course B. April 23 to May 4, 1990, In-Residence Course B is an extremely concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Medical Institutions, Baltimore. Contact: John K. Frost, MD, or Ms Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, USA, (301) 955-8594.

2-3 — Advances in Oncology — 1990. Hyatt Regency Hotel, Lexington, KY. Presented by Department of Surgery and Continuing Medical Education, University of Kentucky. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

9-11 — "Dermatology for the Non-Dermatologist," sponsored by The Ohio State University Center for CME. Hyatt on Capitol Square, 75 E. State St., Columbus, OH. Contact: Ohio State's Center for CME, (800) 492-4445 or (614) 292-4985.

16-18 — Pediatrics in Progress. Hyatt Regency Embarcadero, San Francisco, CA. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

22-24 — New Orleans AIDS Conference: Management of HIV Disease for the Primary Care Physician. New Orleans Hyatt Regency Hotel. Contact: Mr Bart Reilly, AIDS Education and Training Center, 1541 Tulane Ave, New Orleans, LA 70112, (504) 568-3855.

23-24 — Infectious Diseases: Common Problems. Hyatt on Capitol Square, 75 E State St, Columbus, OH. Presented by the Ohio State University Center for Continuing Medical Education; co-sponsored by the Ohio State's Division of Infectious Diseases. Category I credit of the Physician's Recognition Award — 11.25 hours. American Academy of Family Physician credit — 11.5 prescribed hours. Contact: Lori Elliott, The Ohio State University Center for Continuing Medical Education, (614) 292-4985 or (800) 492-4445.

February 25-March 2 — 21st Family Medicine Review — Session I. Hyatt Regency Hotel, Lexington, KY. Presented by Department of Family Practice and Office of Continuing Medical Education. Total 50 credit hours. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

MARCH

2-3 — 33rd Annual Postgraduate Symposium in Ophthalmology — Corneal Disease, sponsored by The Ohio State University Center for Continuing Medical Education. The conference qualifies for 12.5 hours in Category I of the Physician's Recognition Award of the American Medical Association. Registration fee is $200 for physicians and $100 for non-Ohio State trainees (with a letter from their program director). Contact: Ohio State's Center for Continuing Medical Education (800) 492-4445 or (614) 292-4985; or Lori Elliott, Hospitals Communications (614) 459-3909.

4-9 — 17th Annual Critical Care Medicine Course. Holiday Inn Airport West, Oklahoma City, OK. Accreditation granted by The American Medical Association, The American Academy of Family Physicians, The American Osteopathic Association and The American College of Emergency Physicians. Contact: D. Robert McCaffree, MD, or Dora Lee Smith, Critical Care Medicine Course, University of Oklahoma Health Sciences Center, Room 3 SP 400, PO Box 26901, Oklahoma City, OK 73190; (405) 271-5904.

30 — "Pancreatitis in the 1990s: Diagnostic and Therapeutic Advances," sponsored by the Department of Surgery at the University of Cincinnati Medical Center. This course has been submitted for 7 CME credit hours. Cost: $75.00. Contact: Aaron S. Fink, M.D.

30-31 — Contemporary Pediatrics for the Practicing Physician. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

30-April 1 — Pediatrics 1990. Marco Island Hilton Hotel, Marco Island, FL. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

APRIL

5-6 — 17th Annual Symposium on Obstetrics & Gynecology. Washington University Medical Center, St. Louis, MO. AMA Category 1 approved. Contact: Cathy Caruso, Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

6-7 — Aggressive Management of Diabetes and Obesity. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

6-7 — Clinical Advances in Treatment of Retina, Vitreous, and Uveal Diseases for the Practicing Ophthalmologist. Marriott's Griffin Gate Resort, Lexington, KY. Contact: Karen Heidorn, Humana Hospital-Lexington, 150 North Eagle Creek Drive, Lexington, KY 40509, (606) 268-3754.

21 — Annual Oropharyngeal Cancer Symposium, "The Management of Post Treatment Problems in Head and Neck Cancer Patients," Health Sciences Center Auditorium, Louisville, KY. Co-sponsored by the American Cancer Society, Kentucky Division, the Kentucky Cancer Program, and the James Graham Brown Cancer Center. Contact: Pat Warring (502) 588-7870.

POP QUIZ FOR INVESTORS

(Cover the answers . . . Don't cheat!)

Q. If you have an investment with a 7% yield, free from Federal and Kentucky Income Taxes, and free from Kentucky Intangibles Tax, how much yield is required to equal this on a fully taxable investment?

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A. Usually 2%-4% on individual bonds; 4% and up for mutual funds.

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Q. Are there mutual funds investing exclusively in Kentucky bonds?

A. There are three. The Churchill Fund, Flagship Fund and Dupree Mutual Funds (two series).

Q. Are any of these no-load funds?

A. Only the Dupree Funds. The others have a 4% or greater maximum load.

Q. What else do I need to know?

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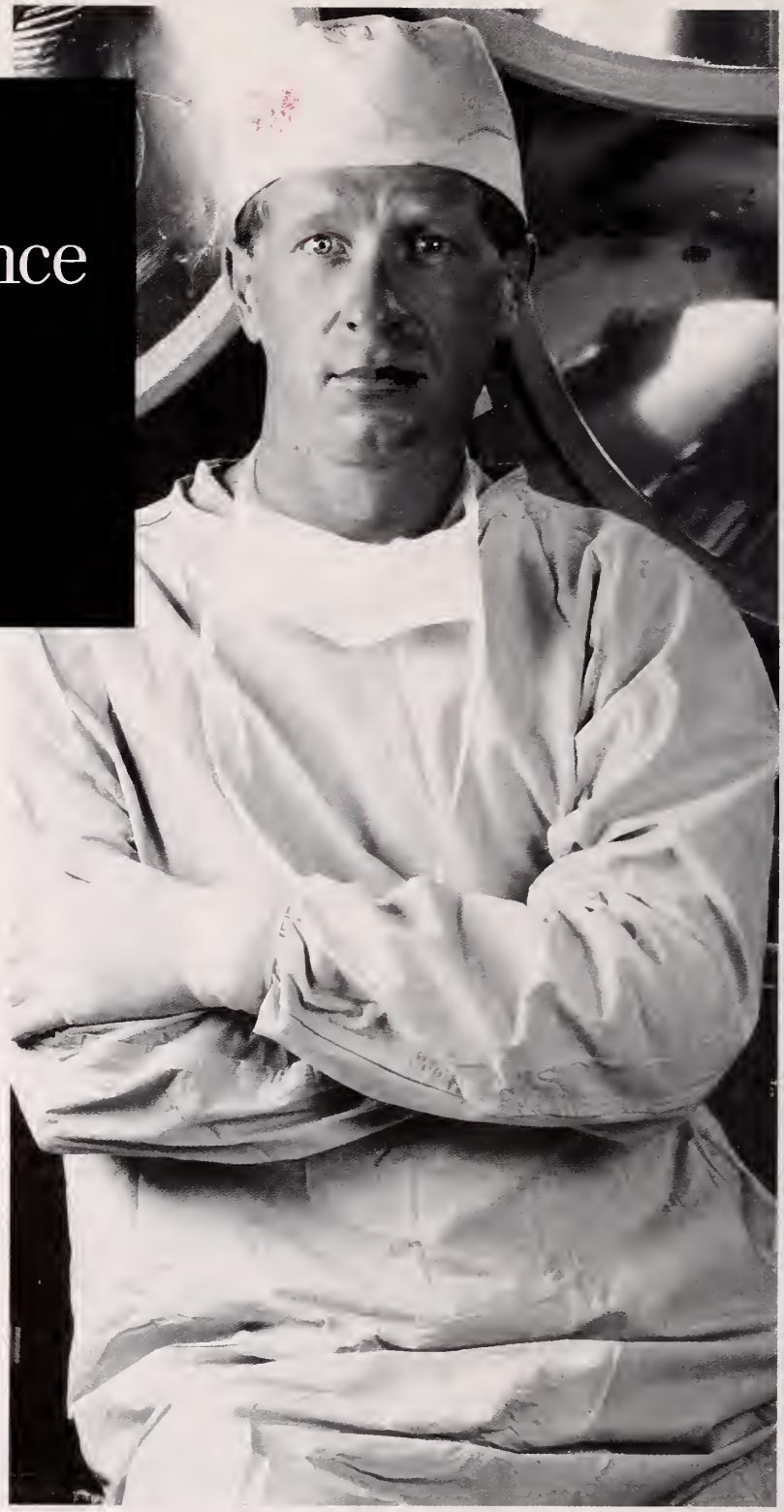

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Economic Impact of Motor Vehicle Restraints in Kentucky

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Prioritizing Health Care

America's health care system was founded on equal access to care for everyone, without regard to income.

In the early days, cost shifting was common to assist patients who could not afford care. In 1964, Medicare and Medicaid were created which coincided with a rapid increase in health care coverage by the private sector. Under Medicare and Medicaid, as well as private insurance, coverages were expanded.

There followed a pell mell increase in cost of health care. Along with an increase in coverage, technology exploded in medicine with the advent of cardiac surgery, organ transplantation, patient monitoring, and testing. We developed ICUs, CCUs, neonatology units. Through the late 60s and early to middle 70s, hospitals expanded, medical schools increased enrollment, and allied health services sprang up all over. The system had no fiscal restraints. The elderly population had significantly increased and they used the system to a greater degree because of increases in the incidence of problems as well as chronicity of their medical problems.

In 1980, business and government started to analyze the future. Corporations looked at health care cost as one of their biggest problems in competing in a world market. The federal government faced a budget that had marked increases in health care cost for Medicare and Medicaid.

In 1983, DRGs were implemented by the government, and the private sector looked to HMOs, PPOs, and managed health care plans. During the same period of time, increasing numbers of people fell through the cracks of the system. In Kentucky, there are about 220,000 indigent people. In the US, it is estimated to be about 30-40 million.

Most states attempted a quick fix method by cutting the budget by reducing the number of people eligible for services and lowering reimbursement to providers. PPOs, HMOs, and managed health care plans did the same in the private sector to cut costs.

We now have an increase in the number of indigent or people uncovered by any health plan, private, Medicare and Medicaid. In order to increase the number of people we provide services to, we must begin to look at priorities.

'Due to the relentless rise in health care costs and severe state or federal budget restraints, we must now think about prioritizing health care. We may have to limit services for one person out of 250,000 who may die no matter what is done, yet use those same funds to take care of markedly increased numbers of people through prenatal care and immunizations which is considerably more cost effective.'

On one hand, we treat patients with severe end-stage disease which may cost $250,000 while, on the other hand, payment for preventive or prenatal care, immunization for the young, and flu shots for the elderly are often excluded.

It has not been long since the original heart transplant was performed in Kentucky. Hospital and surgical costs were reimbursed through Medicaid. At the same time, immunization serum was unavailable through health departments because of cost.

Everyone wants high quality medical care, and physicians strive to provide the best care possible. However, state and federal legislators have been extremely reluctant to address the indigent care problem.

As a nation, we believe health care is a right. Up to now, there hasn't been any sympathy for rationing of health care by age or any other basis. Due to the relentless rise in health care costs and severe state or federal budget restraints, we must now think about prioritizing health care. We may have to limit services

for one person out of 250,000 who may die no matter what is done, yet use those same funds to take care of markedly increased numbers of people through prenatal care and immunizations which is considerably more cost effective.

It is time to address this problem, but we need to include the public, legislators, and the medical community. State and federal legislators must listen to us. Government refused to listen to us in the early 60s when Medicare and Medicaid were enacted. If they fail to listen now, the health care system could become a two-tier system, "one for the haves, and one for the have nots."

Those of us who deliver health care, and the patients who receive that care, must be joint partners in any proposal which basically alters the present system.

'Those of us who deliver health care, and the patients who receive that care, must be joint partners in any proposal which basically alters the present system.'

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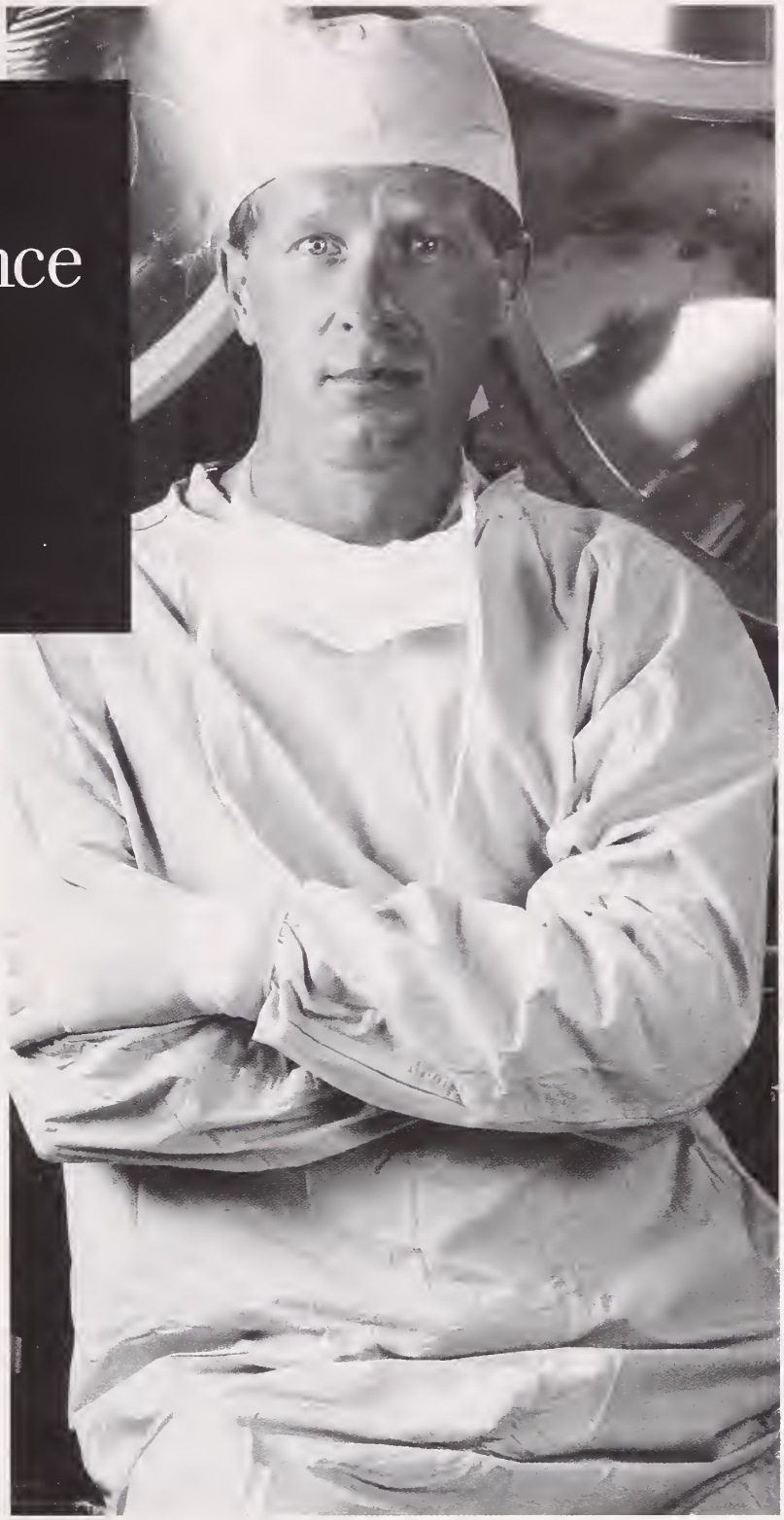

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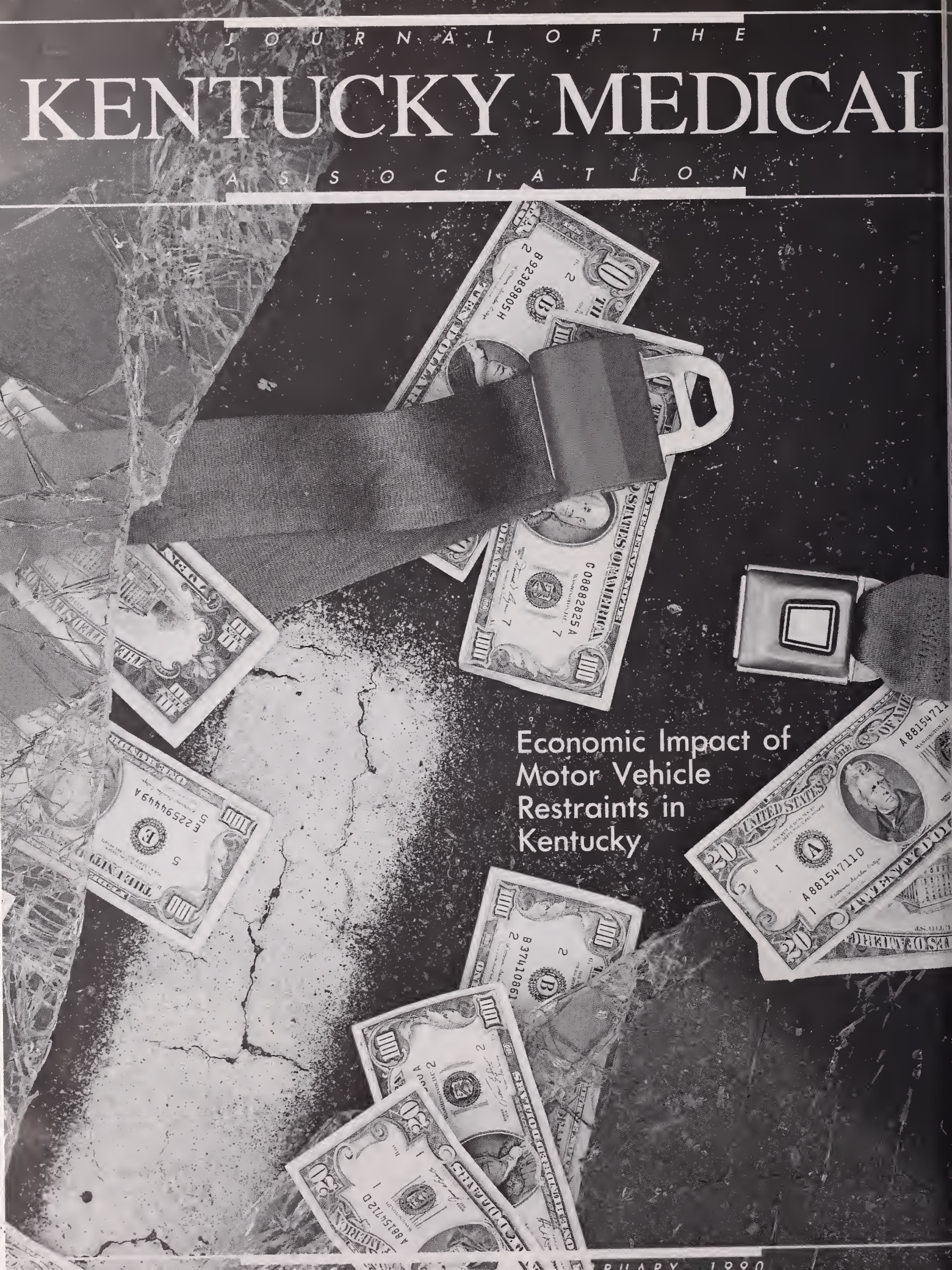

Economic Impact of Motor Vehicle Restraints in Kentucky

FEBRUARY 1990

Economic Impact of Motor Vehicle Restraints in Kentucky: A Trauma Center's Experience

Edmond A. Hooker, MD; Daniel F. Danzl, MD; Donald M. Thomas, MD; Frank Miller, MD; Walter Zupances

Motor vehicle seat belts save lives and decrease the cost of care. Victims involved in motor vehicular accidents requiring ED evaluation and in-patient care were evaluated for seat belt usage. In addition to outcome parameters, the economic impact was assessed. During the five month study period, 38 (14%) restrained drivers and 238 (86%) unrestrained drivers were entered. Unrestrained drivers were more likely to be killed or disabled. The average cost of medical care for unrestrained drivers ($18,165) was significantly higher than that for restrained drivers ($7,634) ($p < .02$) Twenty-eight percent of the unrestrained drivers' bills were paid with public funds. Assuming mandatory seat belt legislation would alter usage patterns as demonstrated in other states, the Commonwealth of Kentucky could save not only lives but millions of tax dollars.

From the Department of Emergency Medicine (Drs Hooker, Danzl and Thomas), and the Department of Surgery (Dr Miller), University of Louisville School of Medicine; and Humana Hospital University of Louisville (Mr Zupances), 550 S Jackson St, Louisville, Kentucky 40202.

Introduction

Properly adjusted motor vehicle seat belts save lives.[1-3] There is conclusive evidence in other states that wearing seat belts reduces medical cost in nonfatal crashes.[4-7] Since for many patients the cost of medical care is borne by the Commonwealth, every taxpayer is directly affected by a vehicle occupant's decision not to buckle up. In addition to the public health considerations, perhaps it was these economic pressures that helped sway 34 states to pass mandatory seat belt legislation. Since Kentucky currently lacks a comprehensive seat belt law, we decided to evaluate the resultant economic impact in Kentucky.

Methods

We examined all victims involved in motor vehicle accidents admitted during a five-month period in 1989. The University of Louisville is an accredited Level I trauma center. Physicians from the Departments of Emergency Medicine and Surgery evaluated these patients, who were subsequently admitted to a designated trauma service.

The patient population was simply divided: unrestrained (UR) and restrained (R), passenger and driver. Demographic and fiscal variables, disposition, and outcome were tabulated. Standard statistical analysis was applied, and the results were evaluated using an unpaired T test.

Results

During the five-month study period, 276 drivers in MVAs were admitted to the trauma service. Most of these, 238 (86%), were unrestrained, while only 38 (14%) were restrained. The average age was 35 years in the unrestrained group and 34 years in the restrained group. The majority of the patients were male (n = 184) (67%). There were no statistically significant differences regarding restraint status by sex. The average medical cost for the unrestrained victim ($18,165) was significantly higher than that for the restrained victim ($7,633) ($p < .02$) (Table 1). In the unrestrained group of 238 patients, 67 (28.3%) were "publically funded," 52 (21.8%) were "private pay," and 119 (49.9%) were "private insurance" (Table 2).

Table 1. Hospitalized Drivers in Motor Vehicle Accidents
February 1-May 30; September 1-October 30, 1989

	Total	Restrained	Unrestrained
Number of Patients	276	38 (14%)	238 (86%)
Hospital Cost	$4,613,365	$290,076	$4,323,289
Average Hospital Cost Per Patient	$16,715	$7,634	$18,165

Table 2. Fiscal Analysis

Percentage Source	Restrained	Unrestrained
% Public funded	7 (18.4%)	67 (28.3%)
% Private pay	10 (26.3%)	52 (21.8%)
% Private insurance	21 (55.3%)	119 (49.9%)

Table 3. Outcome

	Restrained	Unrestrained
Fatalities	0	5
In-patient rehabilitation	1	16
Discharged	37	216

Table 4. Injury Severity Score (ISS)

	Restrained	Unrestrained	(P)
Tennessee Study R4	4.44	8.28	< .05
New Mexico Study R5	2.0	3.6	< .05
Chicago Study R6	1.8	4.51	

There were five deaths in the unrestrained group, compared to zero in the restrained group. Two of the deaths were secondary to severe closed head injuries and three were secondary to internal injuries. Sixteen (6.7%) of the unrestrained drivers were admitted to long term facilities or rehabilitation units (Table 3). Disabilities included seven severe closed head injuries, eight orthopedic injuries, and one spinal cord injury. Only one (2.6%) of the restrained drivers required in-patient rehabilitation for a fractured femur.

During the same study period, data was collected on admitted passengers of motor vehicle accidents. There were only 99 passengers during the study period. Most of these, 90 (90%), were unrestrained, while only 9 (10%) were restrained. Although there was a higher medical cost for the unrestrained victims ($14,045) compared with the restrained victims ($9,121), the results did not reach statistical significance (P = .46) because of the small number of victims.

Discussion

Mandatory seat belt legislation is in force in 34 states. Of these, nine are primary laws, and 25 are secondary laws. Primary laws allow police officers to issue a citation without observing a coexistent violation. Secondary laws require another type of violation before the officer can issue a seat belt citation.

There is ample international evidence that vehicle restraints save lives and dollars. In one study there was a 42% decrease in hospital admissions and a 27% decrease in death rate.[3] A Tennessee study reported a significant increase in the rate of hospitalization for unrestrained victims (UR = 59%, R = 26%: $p < .05$).[4] They also observed a significantly higher injury severity in unrestrained victims. The cost for care of unrestrained victims was markedly increased (UR = $9,631; R = $3,429). Two other studies[5, 6] also reported a decrease in injury severity (Table 4) and hospital cost (Table 5).

Our data reveals that it cost 138% more to care for unrestrained drivers of motor vehicle accidents ($18,165 [UR] vs $7,634 [R]) in Kentucky. In the present study, 28.3% of the patients were publicly funded and 21.8% were private pay. Assuming all drivers in this study had been wearing seat belts, we project $2.5 million would have been saved. The state of Kentucky could have conserved an estimated $705,577 during the five-month period.

Mandatory seat belt legislation has been previously debated in Kentucky, although the issue of cost has not been fully addressed. The projected savings demonstrated in this study are very conservative. The additional costs of physician care and rehabilitation were *not* included. Although we only evaluated admitted victims, ongoing studies are currently evaluating costs for all motor vehicle accident victims both at a trauma center and at a private community hospital.

Table 5. Cost of Injuries**

	Restrained	Unrestrained	(P)	% Increase
Tennessee Study	3,429	9,631	p < .05	178%
Mexico Study	662	2,569	p < .05	288%
Chicago Study	534	1,583	p < .0008	196%
Louisville Study*	7,034	18,165	p < .02	138%

*Only includes hospital charges.
**Current Study; only analyzed drivers in motor vehicle accidents

Popular myths regarding the hypothetical medical hazards of seat belts are no longer debated elsewhere. Less than 0.5% of accidents result in fire or submersion of the vehicle. Drivers who buckle are less likely to be seriously injured or disabled, will spend less for medical care, and are less likely to be fatally injured.

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Surgical Repair of Atypical Coarctation of the Abdominal Aorta in an Infant

Allan H. Rees, MD; Francisco Elbl, MD; Juan Villafane, MD; Robert Solinger, MD; Constantine Mavroudis, MD; Harold Harrison, MD

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A seven-week-old infant with multiple areas of coarctation of the abdominal aorta and renal artery pathology underwent staged surgical repair of his malformations in our medical center. The clinical and routine echocardiographic evaluations suggested the diagnosis of atypical coarctation of the aorta. The exact anatomical characteristics of his vascular malformations were established by repeated angiocardiographic studies, which should be performed in any patient in which the diagnosis of atypical coarctation of the aorta is suspected.

Coarctation of the abdominal aorta is a rare vascular anomaly that can occur in a localized (segmental) or diffuse (hypoplastic) area of the aorta.

It can be of congenital origin or secondary to diseases such as congenital rubella, Takayasu's arteritis, idiopathic hypercalcemia and von Recklinghausen's disease.[1,2,3]

We report an unusual case of an infant in which we were able to document the presence of multiple areas of coarctation of the abdominal aorta associated with renal artery pathology in which eventual successful staged surgical repair of these malformations was accomplished.

Case Report

A seven-week-old infant was transferred to our institution for evaluation and treatment of severe congestive heart failure. He was the product of a normal term delivery and his birth weight was 3.5 Kg. There was no family history of neurofibromatosis or cafe au lait spots.

At the time of admission the patient was in critical condition with clinical evidence of poor peripheral perfusion and marked cardiorespiratory distress. His blood pressure in the left arm was 110/70 mm Hg and in the left leg 80/70 mg Hg. No significant heart murmurs were heard over the precordium or abdomen. The liver was palpable at 4 cm below the right costal margin. A chest roentgenogram showed bilateral pulmonary edema and cardiomegaly. The electrocardiogram disclosed biventricular hypertrophy.

Echocardiography demonstrated normal intracardiac anatomy with a dilated, poorly contracting left ventricle. The aortic arch was normal. The erythrocyte sedimentation rate was 10 mm/hour and the tuberculin test was negative. Urine analysis, serum biochemistry, complete blood count, and serum immunoglobulins were normal. After his clinical condition was improved by the use of intravenous inotropic support and diuretic therapy, he underwent a cardiac catheterization and angiographic studies. An aortogram showed several areas of coarctation of the abdominal aorta (Fig 1) and a complete occlusion of the right renal artery and right iliac artery. Two days after undergoing this study, he was taken to the operating room where a thoraco-abdominal incision was made so as to expose the abdominal aorta. Multiple areas of segmental coarctation of the aorta were identified. The aorta was cross clamped above the inferior mesenteric artery. The origin of the left renal artery, superior mesenteric artery, and celiac artery was occluded with Spencer tourniquets. A longitudinal incision of the abdominal aorta was made along the areas where the segmental coarctations had been identified (Fig 2-A). A large piece of Gore-Tex patch, that had been cut and tailored in a longitudinal manner, was then sutured in place using 6-0 running Prolene (Fig 2-B). Once the patch aortoplasty of the abdominal aorta was completed, clots from the right iliac artery were removed and the Gore-Tex graft was then extended to the origin of the right iliac artery. After a stormy postoperative course, the infant was eventually discharged home on digoxin, diuretic, and antihypertensive therapy. He continued to be followed as an outpatient by the pediatric cardiologists and a pediatric nephrologist. Blood pressure readings at the time of the initial follow-up visit were 128/72 mm Hg on the left arm and 120/70 mm Hg on the left leg. The blood pressure in the right leg was unobtainable. A weak right femoral pulse was present at the time of examination.

He was readmitted to our hospital shortly after his second birthday with a hypertensive crisis and clinical findings of congestive heart failure. On admission, his blood pressure on the right arm was 240/150 mm Hg. His hypertension was

controlled with intravenous Diazoxide and his congestive heart failure rapidly subsided with the help of diuretics and fluid restriction. A renal scan performed on this admission showed no isotope uptake on the right kidney and minimal isotope uptake on the left kidney. An aortogram (Fig 3) performed shortly afterwards showed an irregular dilatation of the entire abdominal aorta. No areas of significant residual coarctation of the aorta were present. The right common iliac artery appeared to be obstructed and collateral flow supplied the right external iliac artery. The renal arteries could not be visualized. In view of the above findings,

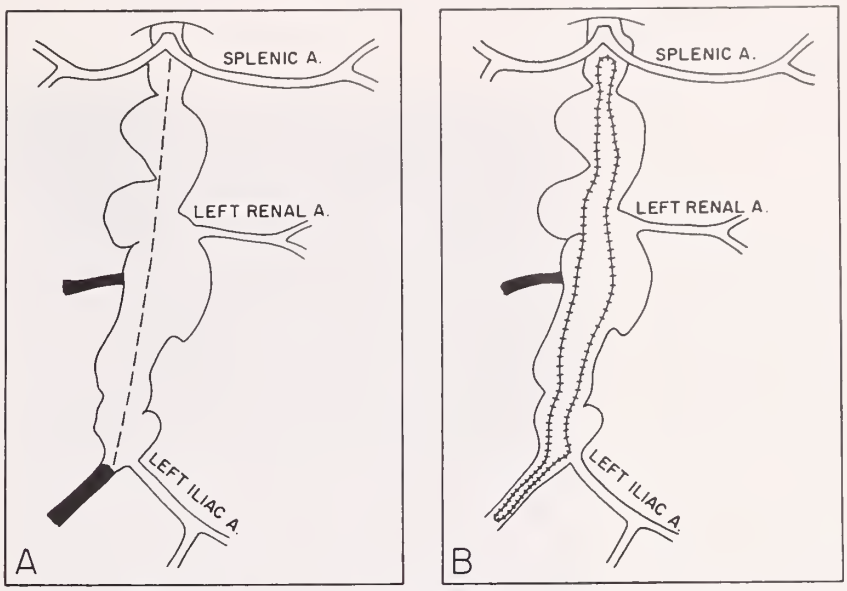

Fig 2 — Operative technique used to repair multiple abdominal aortic coarctations (A). The appearance of the abdominal after patch angioplasty (B).

Fig 1 — Abdominal aortogram demonstrating multiple areas of coarctation in the abdominal aorta (arrows).

Fig 3 — Postoperative abdominal aortogram performed at age two years showing no areas of significant residual coarctation of the abdominal aorta and no flow into the right common iliac artery or into the renal arteries.

Fig 4 — Renal scan performed at age four years showing satisfactory flow to the left kidney.

a reoperation was recommended. At the time of surgery, the right kidney was found to be totally infarcted and therefore was removed. The left renal artery appeared to be significantly stenotic in its proximal portion. Revascularization of the left kidney was accomplished using a saphenous vein homograft sutured between the aorta and the side of the renal artery, bypassing the stenotic area. He recovered well from this second operation and was eventually discharged on several antihypertensive drugs (Captopril, Hydralazine, Inderal and Lasix). He was closely followed as an outpatient and did well for a period of two years. At age 4 years, he was again readmitted to our hospital due to the fact that he had presented a progressive increase in his blood pressure that could not be controlled medically. His right arm blood pressure in the hospital was 152/100 mg Hg. A renal scan performed on this admission showed a decrease isotope uptake in the left renal parenchyma suggesting reobstruction of blood flow within the left renal artery. A third operation was recommended. In the operating room the previously placed graft was found to be nearly totally occluded with redundant tissue. The venous graft was therefore taken down and replaced by a 5 mm Gore-Tex graft that was sutured from the aorta to the lateral aspect of the renal artery, bypassing the previously diagnosed area of stenosis.

A renal scan performed after surgery (Fig 4) showed satisfactory flow to the left kidney without evidence of obstruction. Prior to discharge from the hospital his blood pressure in the left arm was 130/75 mm Hg and in the left leg 120/70 mm Hg. Pressures could not be obtained from the right leg. Periodic evaluations performed since his last discharge from the hospital have established that he continues to have normal blood pressures in both upper extremities and left lower extremity in association to a normal renal function.

Discussion

The exact location and anatomical characteristics of an atypical coarctation of the aorta have to be known before surgery so that the surgeon can plan the type of corrective surgical approach to use and avoid an unnecessary thoracotomy. It is also important to establish the condition of the renal arteries in these patients since renal artery abnormalities can be associated with coarctation of the abdominal aorta.[4]

In many medical centers coarctation of the aorta is repaired without performing a preoperative cardiac catheterization and angiographic studies if the defect can be identified by echocardiography and if the clinical examination suggests the diagnosis.[5] In the patient we have discussed, proper anatomic delineation of the vascular malformations was possible because angiographic studies were performed. State-of-the-art diagnostic techniques, such as Digital Vascular Imaging (DVI) or Magnetic Resonance Imaging (MRI) could have been used to make the correct diagnosis in this particular case, but not all centers have the capabilities to perform these studies. Based on our experience in the management of this infant, we recommend that a cardiac catheterization and angiographic study be performed in any patient in which the clinical and routine echocardiographic evaluation suggests the diagnosis of atypical coarctation of the aorta. In view of the fact that late, or recurrent, impairment of the renal blood flow can occur in these patients after their initial surgery, it is recommended that they have periodical evaluations of their blood pressure and renal function.

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Hot Tub *(Pseudomonas)* Folliculitis

Joseph F. Fowler, Jr, MD, George C. Stege, III, MD

From the University of Louisville School of Medicine, Division of Dermatology, 310 E Broadway, Suite 100, Louisville, KY 40202.

Folliculitis caused by Pseudomonas aeruginosa *is a rare, adverse effect of the therapeutic or recreational use of hot tubs, whirlpools, and occasionally swimming pools. The condition is characterized by painful, papulopustular skin lesions often accompanied by low-grade fever, malaise, and other systemic symptoms. Prompt recognition and treatment may shorten the duration of the disease and, more importantly, prevent further cases by identifying the source of exposure.*

Pseudomonas aeruginosa is a well-known cause of urinary tract infection in hospitalized patients, especially those with a catheter or with other risk factors such as immunosuppression. In healthy individuals it is an unusual pathogen. In recent years there have been several published reports of cutaneous *Pseudomonas* infection after exposure to contaminated water in swimming pools and hot tubs.[1-6] The clinical syndrome is fairly distinctive. As hot tubs and spas become more widespread, "hot tub folliculitis" may also become more common.

Case Reports

Case 1: A 36-year-old man presented with a one- to two-day history of painful papules and pustules primarily located in the genital and axillary areas. For 24 hours he also felt ill with fever, chills, and malaise. He had used a hot tub several times in the previous three days. Others had used the tub and one child had similar symptoms and signs, though not as severe.

A clinical diagnosis of hot tub folliculitis was made and the patient was given an antibiotic ointment and cephalexin 250 mg, qid. A skin biopsy showed folliculitis. Bacterial cultures showed only normal skin flora, however. Within 48 hours his skin eruption had cleared almost completely and he felt well. He reported that his hot tub had shown a chlorine reading of zero.

Case 2: A 28-year-old woman had a two-day history of painful bumps on her buttocks and sides. Her husband had a few similar lesions. They used a hot tub 24 hours before the onset of the rash. There was no itching. She felt well except for a low-grade fever.

On examination, a striking, erythematous, papular eruption was present primarily in areas covered by her bathing suit, including the flanks, breast, abdomen, and upper thighs.

The patient was given an antibiotic ointment and cephalexin 250 mg, qid. Subsequently, bacterial culture grew *Pseudomonas aeruginosa.* WBC was 12,800. After 48 hours she was much improved with the skin lesions receding. She completely recovered within one week.

Case 3: A 20-year-old woman presented with painful papules and pustules mostly in the axillae. She had been in a hot tub 24-48 hours previously. There were no systemic symptoms.

Examination showed dark red papules and pustules in both axillae without involvement elsewhere. Because of the typical appearance, the patient was empirically given an antibiotic ointment and cephalexin 250 mg, qid for five days. Bacterial cultures were not obtained. She was much better within two days.

Table 1: Clinical Findings in "Hot-Tub" Folliculitis

- Repeated use of hot tub, whirlpaol, swimming pool
- Painful rash, usually not pruritic
- Red papules and pustules, often in covered areas
- Fever, malaise frequent
- Eye and ear involvement frequent
- Other bathers affected variably
- Resolutian in 7-10 days

Discussion

These three cases, all seen in one dermatology practice over a period of four months, illustrate the rising frequency of this relatively new illness. Each case illustrates certain features of the disease. All three patients had a history of hot tub use several days before the onset of the eruption. In addition, the lesions seen on each patient were typical of *Pseudomonas* folliculitis: dark red papules and pustules primarily in intertriginous areas or in areas covered by clothing. Biopsy or bacterial cultures are confirmatory, but often not necessary when the clinical pattern is typical. Two of the three patients had systemic symptoms and all recovered well without sequalae. Treatment was not essential but may have shortened the course of the illness. Ciprofloxacin would have

been used if it had been available at the time.

McCausland and Cox[1] in 1975 were the first to report this entity. One year later, Washburn et al[2] identified a similar outbreak among guests at a motel in Minnesota. Thirty-two of 61 persons who used either the swimming pool or whirlpool developed a characteristic rash, while no rash was found in the 37 guests who had not used either pool. Six of the 32 (19%) had eye, ear, nasal, or pharyngeal involvement. All of the affected individuals had cleared after seven days, without specific treatment. *Pseudomonas aeruginosa* was cultured from both pools. Levels of bromine or chlorine, the pool disinfectants, were low in pool water.

Since those first reports, there have been several outbreaks of *Pseudomonas* folliculitis detailed in the literature. Most of these articles have appeared in the dermatologic literature,[3-5] however, with only a few in the general medical journals.[6,7] Several consistent features of the disease are present throughout the reports and were found in the patients in this report. The rash is usually painful rather than pruritic. Discrete red papules and pustules are seen, found mostly in areas covered by bathing suits. Eye and ear involvement is common, often accompanied by fever, headaches, and malaise. *Pseudomonas aeruginosa* serotype 0:11 has been the most commonly indentified strain.

A suboptimal level of chlorine or other disinfectant in the pool water has been noted in most of the reports. Also, an excessive number of persons using whirlpools or hot tubs in a short span of time may contribute to overgrowth of *Pseudomonas*. Chandrasekas et al[5] report that although 0.4 to 0.6 PPM of free residual chlorine is considered adequate in pool water, *Pseudomonas aeruginosa* may withstand concentrations up to 3.0 PPM.

Treatment of most cases has been symptomatic. Occasionally topical antibiotics are used. One case of *Pseudomonas* pneumonia and three cases of urinary tract infection required systemic antibiotics.[7] Ciprofloxacin, a new oral quinolone antibiotic, is effective against *Pseudomonas* and should be considered the treatment of choice, if treatment is needed.

Although usually a self-limited condition, early diagnosis of hot tub or *Pseudomonas* fol-

Fig 1 — Typical locations of lesions seen in patient #2.

Fig 2 — Closeup view of papules and pustules from patient #3.

liculitis is important in order to limit further exposure to the source of infection, to avoid unnecessary diagnostic and therapeutic maneuvers, and to properly treat the patient, if indicated. Undoubtedly, as the prevalence of public and private spas and hot tubs increases, more physicians will be confronted with this disease. The striking physical findings of acute, painful papulopustules, along with the history of exposure to hot tubs or pool should alert the clinician to the presence of this illness.

ACKNOWLEDGEMENT

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To the Editor:

As physicians, we all know that tobacco is deadly. But as informed citizens of the Commonwealth, we rationalize that Kentucky's economic dependence on burley somehow excuses us from speaking out against this number one killer of Americans. Kentucky's "special" relationship with tobacco has some rather grim consequences for its citizens (our patients), particularly for its youth:

1. Kentucky leads the nation in its percentage of smokers (32%).[1]
2. In 1983, approximately 6,000 Kentuckians died of causes attributable to smoking[2] (probably a conservative estimate, since it ignores death from passive smoking and prenatal deaths due to maternal smoking).
3. Kentucky leads the nation both in years of potential life lost (YPLL) due to smoking related illness and in smoking attributable mortality (SAM).[3]
4. Kentucky has the third highest lung cancer rate[4] and sixth highest chronic lung disease rate in the nation.[5]
5. Eight percent ($270 million) of the total cost for direct medical care in Kentucky in 1983 was attributable to cigarette smoking, and inclusion of indirect cost (lost productivity) would raise the total to $435 million.[2]
6. Kentucky is one of only six states which do not prohibit the sale of tobacco products to children.
7. Kentucky schools may actually set aside smoking areas for *students*.[7]

To address some of these problems, the Kentucky Medical Association has assumed a leadership role in protecting the health of our youth. In September, the KMA endorsed resolutions requiring it to work to introduce legislation to prohibit use of tobacco by minors and to prohibit use of tobacco on school property. Further, Kentucky legislators, Dr Jack Trevey (Sen R12), Anne Meagher Northup (Rep D32), and Thomas Burch (Rep D30) have agreed to assume leadership roles in working for this much needed legislation.

Despite the fact that these resolutions concern children (and *nobody* wants children to smoke), passage of such legislation is by no means guaranteed. We can expect to hear (again) the oft-repeated story of Kentucky's economic dependence on tobacco. And it's all true. But so is the fact that tobacco kills more people than all of the following **combined:** AIDS, cocaine, heroin, suicide, homicide, alcohol, fire, and automobile accidents.[8] Most of us are not in a position to affect Kentucky's agricultural policy. But maybe legislation aimed at protecting our youth will help support the efforts of those who are working to develop alternate crops or sources of income for Kentucky tobacco farmers. As physicians, we can't solve this problem for Kentucky farmers. But we can, and should, work to keep their sons and daughters from dying of horrible diseases that ought to have been prevented.

Please, please write to your state legislators, urging them to protect the future health of our children by supporting legislation to prohibit use of tobacco by children on school property and to establish a minimum age for tobacco use by children.

Barbara Phillips, MD
Chairman, Kentucky Coalition of the American Cancer Society, American Lung Association, and American Heart Association

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Q. If you have an investment with a 7% yield, free from Federal and Kentucky Income Taxes, and free from Kentucky Intangibles Tax, how much yield is required to equal this on a fully taxable investment?

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Formula: Yield / (1 – (FIT + (1 – FIT) (SIT) + Intangibles tax)

Q. What investments are free from Federal and Kentucky Income Taxes and the Kentucky Intangibles Tax?

A. Tax-exempt bonds issued by Kentucky and its political subdivisions and mutual funds holding these bonds exclusively.

Q. How much money would be required to diversify my risk over 100 different bonds?

A. $500,000 in individual bonds. Or, about $2,500 in a mutual fund.

Q. What is the sales charge for bonds and funds?

A. Usually 2%-4% on individual bonds; 4% and up for mutual funds.

Q. What does a 4% sales charge do to a 7% yield if the investment is sold in one year? . . . Two years? . . . Five years?

A. It reduces the yield to 3% (one year); 5% (two years); 6.20% (five years).

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Needle Localization and Biopsy of Mammographic Abnormalities

Michael B. Flynn, MD; Elizabeth A. Amin, MD; James G. Kuhns, MD

Preoperative needle localization has been well established as a means of facilitating excisional biopsy of nonpalpable breast abnormalities detected by mammography. Currently the most reliable localization techniques include some form of self-retaining hook or J-wire placed parallel to the chest wall.[1,2,3] The specific procedure in use at the University of Louisville Department of Diagnostic Radiology has proven reliable since its introduction in 1985.[4]

The most common difficulties with the self-retaining localization devices appear to be (a) transection of the wire and (b) displacement from the area of interest during the surgical approach.[5] Both may result in failure to remove the mammographic abnormality in the initial biopsy and may lead to a repeat surgical procedure.

Recommendations regarding a surgical approach to the excision of nonpalpable needle-localized breast lesions, the appropriate management of the tissue specimen by the surgical pathologist, and an update of the experience with needle localization at our institution will be included in this report.

Patient and Methods

An asymptomatic 52-year-old female received a screening mammogram that revealed an abnormality in the upper inner quadrant of the right breast (Fig 1 & 2). The patient was two years postmenopausal, *para* II, *gravida* II, had no family history for breast cancer, and an essentially unremarkable past medical history.

From the Departments of Surgery, Division of Surgical Oncology, and Diagnostic Radiology, University of Louisville School of Medicine; the James Graham Brown Cancer Center; and Department of Pathology, Norton Hospital, Louisville, KY.

Reprint requests to Department of Surgery, University of Louisville, 550 S Jackson St, Louisville, KY 40292 (Dr Flynn).

Fig 1 — Right mediolateral oblique.

Fig 2 — Right craniocaudal projections showing the stellate mass in upper inner quadrant.

Fig 3 — Craniocaudal radiograph showing Kopans localizer placed from the medial skin surface. Tip of hook is at posterior margin of mass at a distance of 4 cm from skin entry site.

Fig 4 — Biopsy radiograph (1.5 magnification). Tumor extends to cut surface.

Needle localization procedure and biopsy were carried out (Fig 3) and revealed invasive ductal carcinoma. On histologic examination, the tumor was found to extend to one margin of excision (Fig 4). The patient selected breast conservation approach and subsequently re-excision of the biopsy site and axillary node dissection were performed. No tumor was found in the re-excision site and the axillary nodes were negative. Hormone receptor analysis revealed estrogen 11 and progestin of 7 Fmol/mg cytosol protein. Radiation therapy (5000 centigray [cGy]) was delivered to the breast.

Procedure — Review of the mammograms by the radiologist and surgeon determines relationships between the localizing wire, the mammographic abnormality, the skin, and the nipple. A curvilinear incision over the area of mammographic abnormality is preferred (Fig 5A). The skin incision is usually made with a cold knife and the remainder of the dissection carried out using electrocautery. Skin flaps are not raised.[6] Dissection is carried out directly through the breast down to the area of the abnormality and then a core of breast tissue is excised (Fig 5B). Optimally, the lesion is surrounded by a 1-2 cm rim of normal breast tissue. The localizing wire is divided at the skin edge to avoid inadvertent change of position during manipulation of specimen (Fig 5C). The specimen and the localizing wire are then removed (Fig 5D) and sent for specimen radiography. Frozen section for tissue identification and adequacy of resection may be carried out depending upon the size of the mammographic abnormality. Careful communication with the pathologist is strongly recommended to avoid tissue damage that could prevent further analysis. The optimal specimen contains the mammographic abnormality surrounded by a rim of normal breast tissue (Fig 5E). The skin closure is made in two layers and no attempt is made to obliterate the dead space. (Fig 5F).

Surgical Specimen — The specimen is given to the radiologist along with the presurgical needle localization mammogram. The radiologist will carry out the specimen radiography using the lo-

calization wire or lead markers to orient the specimen. Comparison is then made with the presurgical mammograms to ensure that the suspicious area has been included in the surgical specimen. The radiologist documents all findings. The best circumstances allow the radiologist to take the specimen to the surgical pathologist for orientation. When transportation to the pathologist will be carried out by someone other than the radiologist, orientation on the x-ray film is best achieved using lead markers (Fig 6). This insures that the lesion in question can be readily found by the surgical pathologist.

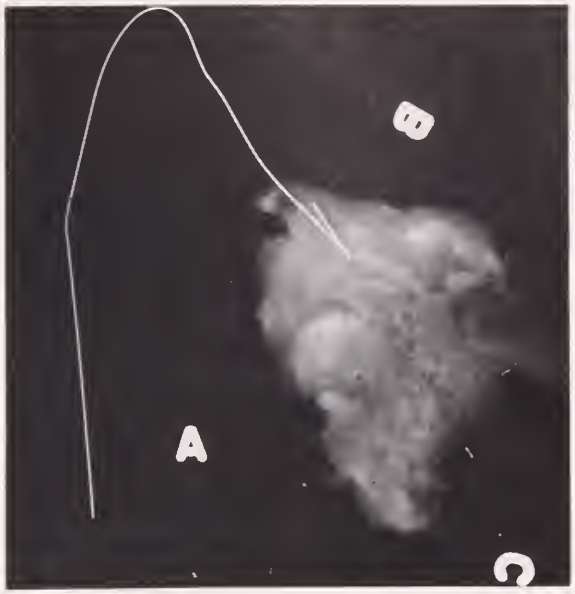

Fig 6 — Specimen radiograph utilizing lead markers (letters) so the pathologist can know where to sample the specimen.

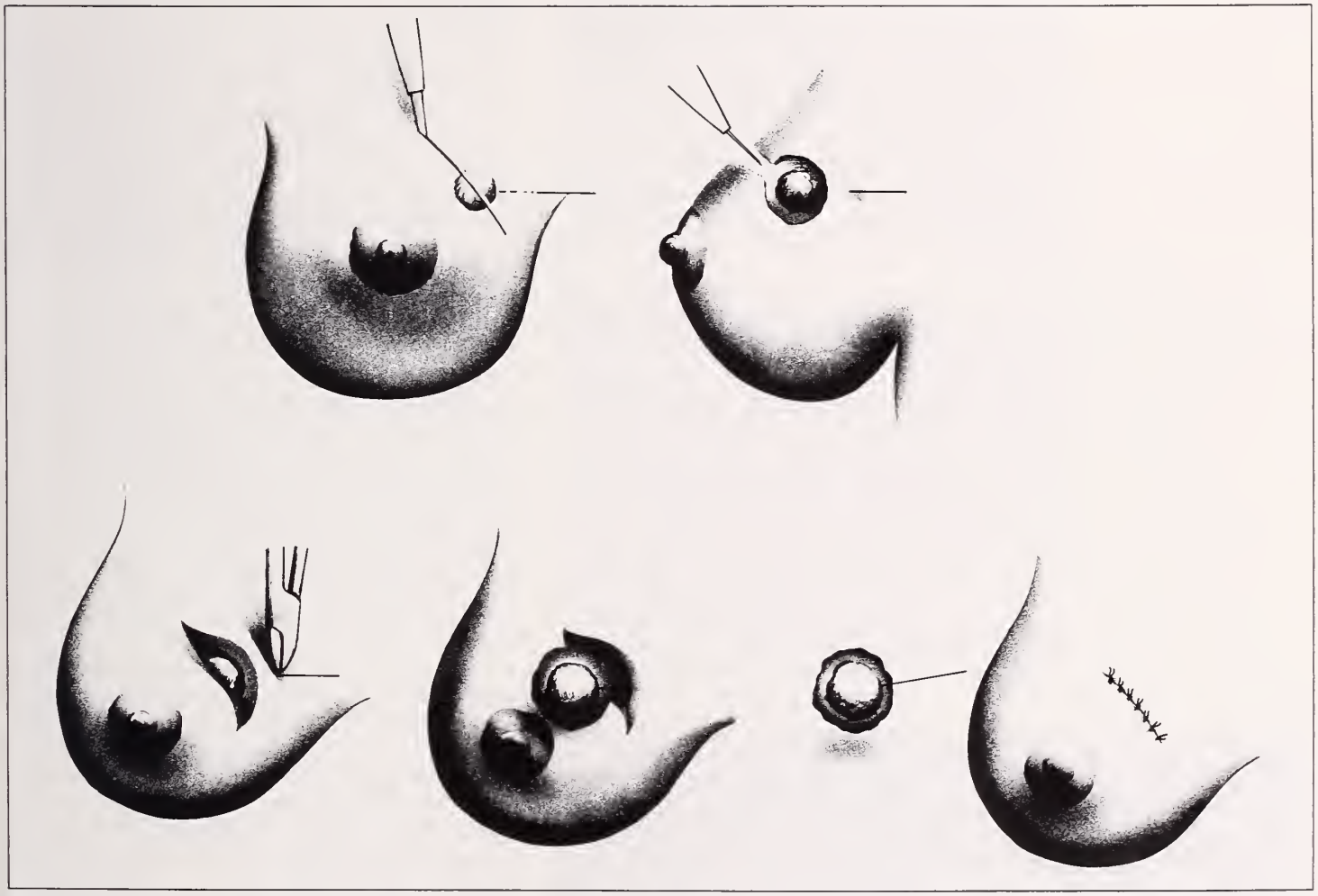

Fig 5 — A) The biopsy technique following needle localization includes curvilinear skin incision made over the mammographic abnormality in upper inner quadrant of the breast and B) dissection continued directly down to the lesion using the electrocautery without undermining the skin. C) The wire is divided by a wire cutter at the skin edge. D) The biopsy specimen is removed through the incision, E) the specimen is surrounded by a rim of normal tissue, and F) two-layer closure of skin and subcutaneous tissues is made with no attempt to close the dead space.

Once the surgical specimen and the specimen radiograph have been oriented, the surgical pathologists can readily block out the area of suspicion and examine it grossly for malignancy. When no grossly suspicious areas for malignancy are seen, the specimen is block sectioned and submitted in designated blocks for permanent section. If an area is grossly suspicious for carcinoma, a small portion may be taken for frozen section to ascertain the diagnosis. Additional portions of the specimen are tested for hormone receptors and retained for permanent section analysis.

If breast conservation surgery is anticipated as one of the alternative therapies, it is very important that the margins of the specimen be marked with a suitable dye before any examination incisions are made. This will allow the surgical pathologist to determine the proximity of the lesion to the surgical margin. If breast conservation surgery is to take place at the time of biopsy, orientation of the specimen using suitable marks such as sutures, should be done by the surgeon. With this method, if a carcinoma is found and there is a close margin, the pathologist can indicate to the surgeon that the margin may be inadequate.

Current Data — Currently, 176 patients have undergone 182 localizations at Humana Hospital, University of Louisville, and the Breast Care Center of the James Graham Brown Cancer Center (Table 1). Malignancies were encountered in 16% (30/182). The results of the first 102 localizations have already been published.[4] In comparison with that initial group (malignancy yielded 14%), the second group of 80 consecutive localizations has yielded 16 malignancies (20%). The localization procedure has not changed in any way since the original report. We do, however, require that all biopsies be radiographed. Prior to July 1987 any mammographic abnormality that could be palpated at the time of the biopsy was excised and submitted to pathology without a biopsy radiograph being performed.

In each group of localizations, over 90% of first biopsy radiographs have included the mammographic abnormality in its entirety. In 12 patients the mammographic abnormality was not seen on the first specimen radiograph but re-excision resulted in the removal of the abnormality in 8 patients. Of the remaining 4, 1 patient required a repeat surgical procedure[4]; 2 patients had no residual abnormality on follow-up mammogram[6]; and histologic diagnosis of carcinoma in-situ was made in 1 on histologic examination of the tissue.

Table 1. Needle Localization of Mammographic Abnormalities
University of Louisville

	1985–1987	1987–1989
Total Needle Localizations	102	80
Total Malignancies	14 (14%)	16 (20%)
Biopsy Radiographs	87	79
Mammographic Abnormality in First Biopsy Specimen	82 (94%)	72 (91%)

Discussion

Needle localization and biopsy of nonpalpable mammographic abnormalities present a special challenge to the surgeon because the tissue to be removed cannot be felt and must be identified by relying upon measurements and instructions provided by the radiologist. Clear communication and a good working relationship between the radiologist, surgeon, and pathologist are critical to the precise identification of this abnormal tissue.

Curvilinear incisions provide a better cosmetic result after breast biopsy than radial incisions.[7, 8] Whenever possible, the skin incisions are placed over the site of the mammographic abnormality rather than over the entry point of the wire through the skin. This approach avoids dissection along the wire which causes manipulation of the wire and increases the risk of dislodgment. Once the area of the mammographic abnormality is located, the guide wire can be divided at the skin entry point also to avoid dislodgment during manipulation of the tissue to be excised.

The cancer detection rate following needle localization and biopsy ranges from 15% to 20%, consequently 80% to 85% of patients are not candidates for further treatment.[4, 7, 8] In addition, a variable percentage of patients with very small cancers will select breast conservation rather than mastectomy. Therefore, the majority of patients who undergo needle localization and biopsy will not be candidates for mastectomy. This emphasizes the need for a surgical approach that is attentive to the postoperative aesthetic result.

A discussion of the treatment options available for breast cancer should be conducted with all patients who undergo needle localization and

biopsy. This is especially important in the patients who indicate interest in the breast conservation approach. Under these circumstances, the identification of a malignancy and adequate excision at the time of initial biopsy avoids either the necessity for re-excision of the biopsy site or the use of localized boost of radiation therapy to the tumor bed.

One method of achieving this goal involves the use of frozen section analysis to identify the presence of malignancy as well as the adequacy of margins. Since there are advantages and disadvantages to the use of frozen section with small amounts of tumor, the method must be employed after appropriate consideration of the circumstances. For very small lesions, when all of the tissue is submitted for frozen section, the tissues may be distorted making histologic diagnosis difficult on permanent section and destroying the ability to identify hormone receptors.

The management of a biopsy specimen suspected of containing a very small lesion requires coordination between the surgeon, radiologist, and pathologist. The correct sequences allows the mammographer to review the specimen, determine that the suspicious area has been removed, and orient the specimen on radiologic film with the localizing wire in place or with lead markers. The radiologist then takes the specimen to pathology for initial evaluation by the pathologist with the clear indication that it needs to be identified for margins. For example, the pathologist after gross examination of a 10 mm suspicious lesion can obtain a thin shaving for frozen section. The remainder of the specimen may be divided in half; one portion to be analyzed for hormonal receptors, the other submitted for permanent section histologic fixation. When a very small 5 mm suspicious lesion is identified, one-half of the lesion can be used for frozen section analysis and the remainder submitted for formalin-fixed paraffin-embedded sections. Immunoperoxidase technique can be used to identify estrogen and progestin receptor activity from permanent section of the specimen. This approach recognizes the risk of tissue distortion by the frozen section process and carefully preserves tissue both for permanent section analysis and for hormone receptor studies. Should further resection be necessary, it can be carried out immediately at a time when the relationships between the excised specimen and the surgical defect are most clear. These special considerations are not necessary for the mastectomy candidate. After a satisfactory identification has been made on specimen radiography, the tissue can be sent to the pathologist for further processing.

Since most mammographic abnormalities are quite small and not palpable, the amount of breast tissue removed is not great. Simple closure of the skin and subcutaneous tissues produces the best cosmetic result.[7, 8] Gravity tends to collapse the dead space and the tissues find the most natural relationship without the puckering and distortion frequently encountered after attempts to remove the cavity are made.

Performing the biopsy after needle localization on an outpatient basis and under local anesthesia reduces cost.[6, 9, 10, 11] Evidence that the type of anesthesia (local versus general) affects the accuracy of excision of the mammographic abnormality is mixed.[6, 9, 10, 11] However, an unacceptably high rate of unsuccessful excision which requires a second procedure cancels the cost effectiveness of local anesthesia.[9, 12] Lesions located superficially in the breast are easily excised under local anesthesia while general anesthesia should be considered for those more deeply situated because of the limitations of patient pain that may inhibit confident excision of deeper lesions.

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Back To The Future

'It has been said that there is nothing new in the world save our rediscovery of the past. With imagination as our tool and caution at our side, let us all seek to enter the new decade with prepared minds and open eyes receptive to creative solutions to our problems . . . whether these solutions be innovative technology or innovative journeys back to the future.'

Welcome to the last century of this millenium. Consider the history of medicine as it bears witness to the compression of history.

In 1908 sulfonamides were first developed as chemicals for the dye industry in Germany. It was nearly 30 years before clinical applications of these chemicals occurred. From 1936 to 1943 extensive testing and development of derivatives occurred as sulfonamides were introduced into medicine and dramatically altered the course of medical practice. One medication altered the face of medicine forever.

While the development of sulfa and its impact on the practice of medicine occurred over nearly four decades, today, equally dramatic changes in the face of medical science occur within years. In the passage of a decade research concepts become clinical practice and common clinical procedures become history.

Consider for a moment what may be commonplace in the 1990s and what the imaginative developments of the 1990s will make obsolete.

Laser angioplasty may not surplant formal reconstructive vascular surgery, but it will certainly become increasingly common. Leg amputation will become rare in the 1990s due in part to this, but also due to the development of other modalities such as atherectomy and the wider application of vessel bypass surgery to involve vessels not previously considered amenable to surgery.

Lithotripsy of gallstones will dramatically alter the practice of general surgery. In the 1990s, in selected cases, this technique will surplant cholecystectomy. Imagine the common cholecystectomy becoming a procedure of the past! Well, admittedly that's an overstatement. It's not likely to be eliminated in the 1990s, but even a reduction of 50% would be a *staggering* change in the complexion of general surgery. There is even the possibility that laparoscopic cholecystectomy will become a safe and viable operation in certain cases in the 1990s.

Some of the most tantalizing innovations of the 1990s will occur in reproductive medicine. It will be possible . . . some say commonplace . . . to test for genetic damage of fertilized embryos at the blastomere stage and even to alter blastomeresis in gene damaged patients such as individuals with G6PD deficiency prior to reimplantation of a fertilized egg. It will be possible . . . some say commonplace . . . to test for disorders such as Huntington's chorea and Down's syn-

'. . . Sometimes the innovations of the future are drawn from creative reconsideration of discarded solutions of the past. After all, one of the most exotic developments to relieve venous congestion in limb reattachment surgery is the application of leeches!'

'In the passage of a decade research concepts become clinical practice and common clinical procedures become history.'

drome at the blastomere stage to permit selective reimplantation.

In the 1990s we will witness the departure of the single most common operative procedure in the United States in the mid 1980s — the D & C. The D & C will become among the rarest of surgical procedures. Endometrial biopsies will be an office procedure. Hysteroscopic exam will permit directed biopsies. Only as a last resort in cases of persistent bleeding might a D & C still be indicated in the 1990s.

But let us not believe for a moment that all of the innovative development of the 1990s will depend on exciting technological developments. While it is all very heady and exciting, sometimes the innovations of the future are drawn from creative reconsideration of discarded solutions of the past. After all, one of the most exotic developments to relieve venous congestion in limb reattachment surgery is the application of leeches!

It has been said that there is nothing new in the world save our rediscovery of the past. With imagination as our tool and caution at our side, let us all seek to enter the new decade with prepared minds and open eyes receptive to creative solutions to our problems . . . whether these solutions be innovative technology or innovative journeys back to the future.

Martha Keeney Heyburn, MD

ACKNOWLEDGMENTS: My thanks to the many distinguished practitioners and academicians who took time to discuss these and other ideas with me, especially Tom Klamer, MD; McHenry Brewer, MD; Marvin Yussman, MD; Thom Zimmerman, MD, PhD; and Hiram Polk, MD.

AKMA Provides Financial Aid for Worthy Students

Since 1946, the Auxiliary to the Kentucky Medical Association has given some degree of financial assistance to worthy students pursuing a career in the allied health field. To be eligible to receive aid, the applicant must be a resident of the Commonwealth of Kentucky, enrolled in an accredited Kentucky school of allied health, be recommended by a physician or auxiliary member, and be in need of financial aid. Posters, applications, and letters are sent to all financial aid departments of the schools of higher education in Kentucky requesting assistance in locating students who are in need of help.

Initially, the aid was in the form of a loan to be paid back after graduation. Fortunately, many recipients did repay the loans, but others did not; to collect the money was becoming more difficult as time passed. In 1987, it was recommended that the loan fund be changed to a grant fund for students in need of financial assistance. In the previous 41 years, approximately $75,000 had been loaned, and in 1987, the first grants were awarded totaling $1,541. In 1988 and again in 1989 a total of $2,000 was given.

The need for financial assistance has grown tremendously. In 1989, the Committee received a total of 32 applications. The Committee had a very difficult job trying to narrow the applicants down to six to be interviewed. On May 31, 1989, the AKMA Health Careers Fund Committee interviewed the six applicants. Mr Don Chasteen, advisor to the AKMA, was also in attendance. It was a very difficult decision as there was only $2,000 for the six grants. The monies that each of the recipients was awarded could be used only for tuition, and the total costs for some schools are often in the thousands of dollars.

The recipients for the 1989-90 year are all pursuing nursing degrees. Julie E. Garst of Franklin and Shannon Marie Finnegan of Louisville will attend Bellarmine College; Karen S. Howard and Jacqueline D. Schartung will be at Owensboro-Henderson Community College; Cheryl Sue Masters of Owensboro will attend Murray State University; and Laura Pickatta of Alexandria will enroll at Northern Kentucky University.

It is a joy to meet the recipients, talk to them about their future goals, and see their enthusiasm as they pursue higher education in the field of medicine.

The Committee members' only regret is that there is not more money available for scholarships. It is the intention of the AKMA to build on the already invested "pay back monies" from previous years. Hopefully, in time, this will generate a sizable interest payment which, in turn, can be awarded as scholarships. Each year, $1 of the auxiliary dues is also allocated to the Health Careers Fund. This year, the auxiliary thanks the KMIC and its Charitable Contributions Committee for donating $500 to our fund. If anyone else wishes to contribute to this worthy cause, it would be greatly appreciated, and you can be assured it will be used wisely to help very grateful students.

Carol Goodin
Health Career Fund Chairman
AKMA
3532 Ephraim McDowell Dr
Louisville, KY 40205

Members of the Health Career Fund are, L to R, Margaret White, Chairman Carol Goodin, Jo-Ann Daus, Betty Schrodt, and AKMA President Esther Jansing.

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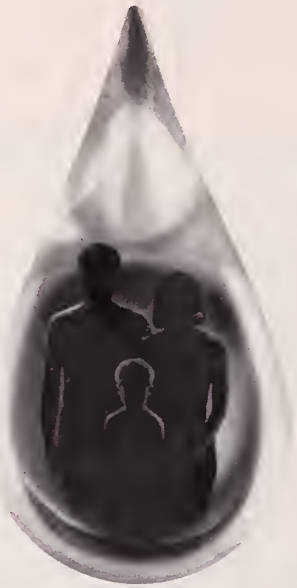

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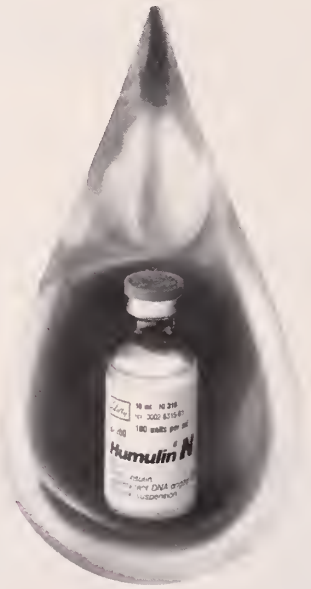

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The Numbers Racket

One day, three doctors and some medical students sat around a conference table — far removed from the wards — impatiently waiting to hear of the new cases of the day.

The medical student, Anxious and Anxious-to-Please, was asked to present the cases. One of the doctors said, "Anxious and Anxious-to-Please, be brief — no fol-de-rol — just give us the numbers — the numbers are what we want."

Anxious-to-Please, hereinafter known as A.T.P., began, "The first patient is a poor historian and I didn't get a history. The physical examination showed . . . "

"Did it reveal any abnormalities?" interrupted Dr. Cocksure, one of the three doctors.

"I don't think so," said A.T.P.

"Well, come on with it, man, and give us the numbers," exclaimed Dr. Technology-Is-Everything, "the numbers, man, the numbers."

"The 'lytes' were as follows," said A.T.P., "Na was 200, Cl 180, HCO_3 5; the BUN was 640, and the creatinine was 0.6."

"Ah, that's easy," responded Cocksure, knowingly. "I can tell that the patient is dehydrated, because the BUN is elevated, the plasma creatinine is normal, and the HCO_3 is low. Furthermore, some sloppy person gave 'hot salt' by mistake. We've got to stop the 'hot salt' and give water."

"Well, I'm not so sure of *that,*" said Technology-Is-Everything with a horrified look of anguish. "I'd like to know what the Ca, P, TP, Alb, urine 'lytes,' renal echo, urine NAGs, SGOT, CPK, GGT, LDH, aldolase, ammonia, amylase, arsenic, bilirubin, carotene, ethanol, lactic acid, magnesium, salicylates, triglycerides, uric acid, cardiac ejection fraction, and pulmonary wedge pressures are. We may be missing something important here."

The last of the three, Dr. Clear-Head, asked quietly, "May we see the patient?"

"Oh come on, Clear-Head!" shouted Cocksure and Technology-Is-Everything simultaneously and disgustedly. "Don't be so pedantic. We've got a lot of ground to cover, man. Next case."

"No! I insist that we see the patient," insisted Clear-Head.

So after a moment's ritual of mumbling and grumbling and with A.T.P. and his colleagues no longer anxious-to-please, but anxious to see a fight, off they loudly went, waking up the dead along the way.

They entered the patient's room, looked in the bed, and Clear-Head exclaimed, "This is a shark — probably a normal shark. A shark is an elasmobranch and elasmobranchs have very high plasma sodium, chloride and urea concentrations. How did this shark get here?"

"I'm afraid I'm responsible," said Technology-Is-Everything. "I was shown the numbers, and anybody with numbers like that should be admitted."

"Well," said Clear-Head, "the challenge here is not to get water into the patient, but the patient into water!"

The moral, dear friends: don't forget to have a look at the patient first. The numbers come last. — WILLIAM B. BLYTHE, MD, *Department of Medicine, University of North Carolina School of Medicine, Chapel Hill, NC 27514.*

Reprinted with permission from *North Carolina Medical Journal,* 1988;49:609.

Highlights of KMA December Board Meeting

The KMA Board of Trustees held its second meeting of the Associational year on December 13-14, 1989, at the KMA Headquarters Office in Louisville.

Nelson B. Rue, MD, reported on his activities since becoming President of KMA in September, to include attending meetings of the AMA, the KMA, Trustee District meetings, and the newly formed Kentucky Coalition on the Availability of Nurses.

Reports were also presented by the AKMA President; KMA Secretary-Treasurer; Senior Delegate to AMA; President of the Board of Medical Licensure; Vice Chairman, KMIC Board of Directors; Dean, University of Louisville School of Medicine; and Commissioner, Bureau for Health Services.

It was noted that KMA membership stood at an all-time high of 5,460 in its combined membership categories, with 4,163 dues-paying members. Legal Counsel reported that KMA had been permitted to file an amicus curiae brief in a court case involving extraordinary means of treatment of terminally ill patients.

The Chairman reported that as a result of the Report of the 1988-89 President, an Ad Hoc Committee on Advocacy Systems had been appointed. He also appointed three KMA Board members to serve with two physicians named by KMIC to the Ad Hoc Committee for the KMIC Board Election Process.

Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, discussed in great length KMA's legislative plans for the 1990 Kentucky General Assembly; and Donald C. Barton, MD, Chairman of the Committee on National Legislative Activities, reported that the issue of most concern to medicine during the recently adjourned Congress dealt with changes to the Medicare law.

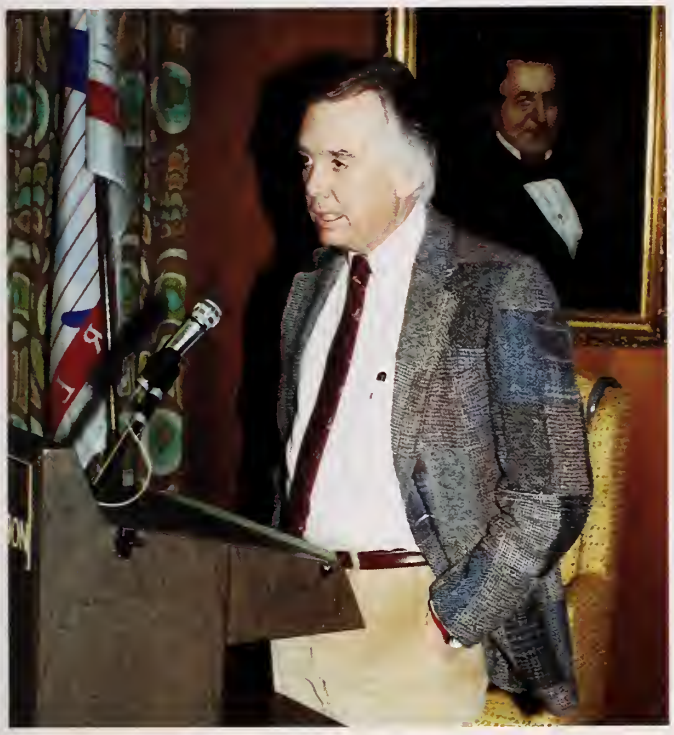
The Board voted to approve renewal of the Blue Cross and Blue Shield health insurance program for members as recommended by the Committee on Medical Insurance and Prepayment Plans. It was reported that the Ephraim McDowell Cambus-Kenneth Foundation, now a legal entity, is in a position to accept ownership of a farm in Danville, Kentucky, once owned by Doctor Ephraim McDowell, upon the death of the current owners.

Larry P. Griffin, MD, Chairman of the Continuing Medical Education Committee, reported that KMA had received notification from the Accreditation Council on Continuing Medical Education that the Committee is functioning effectively. Russell L. Travis, MD, Chairman of the Kentucky Physicians Care Operating Committee, reported that since the inception of the Kentucky Physicians Care Program, 65,387 calls had been placed to the KPC hotline, and 30,255 referrals had been made. Dr Travis noted that meetings have been held with representatives of pharmaceutical companies in an attempt to secure drugs for KPC patients, and that it appeared some help would be forthcoming.

The Board selected names for submission to the Governor for the Advisory Council on Athletic Trainers, and the Board of Licensure for Nursing Home Administrators. It also granted permission to lend the Association's name as a cosponsor of a Kentucky Bar Association seminar on substance abuse, and to participate on a KBA program dealing with medical ethics, the law, and new technology.

The next meeting of the KMA Board of Trustees was scheduled for April 18-19, 1990. *kma*

Reports were presented by, L to R, Secretary-Treasurer S. Randolph Scheen, MD; AKMA President Esther Jansing; and Donald C. Barton, MD, Chairman of the Committee on National Legislative Activities.



Clockwise, Russell L. Travis, MD, Chairman of the Kentucky Physicians Care Operating Committee, reported to the Board on the status of the KPC Program (Chairman William B. Monnig, MD, presided at the head of the table); KMA President Nelson B. Rue, MD, (L), presented a plaque to retiring Speaker Peter C. Campbell, MD, in appreciation of his 12 years of service as Vice Speaker and Speaker of the House; Chairman of the Committee on State Legislative Activities, Wally O. Montgomery, MD, gave his report; and Burns M. Brady, MD, Chairman of the Impaired Physicians Committee, addressed the Board.

Doctor McDowell Farm Given to KMA Foundation

Mr Joe A. Wallace and Mrs Cecil Dulin Wallace signed the Agreement as KMA President Nelson B. Rue, Jr, MD, looked on.

'The official family of KMA has expressed the gratitude and appreciation of the Association for this valuable gift and for the opportunity to preserve this segment of history involving Dr Ephraim McDowell.'

On November 16, 1989, several years of dedicated and endless efforts in creating the Ephraim McDowell Cambus-Kenneth Foundation, Inc, culminated in the signing of an Agreement between Mr Joe A. Wallace and Mrs Cecil Dulin Wallace and the Ephraim McDowell Cambus-Kenneth Foundation, Inc. The Foundation was formed by the Kentucky Medical Association for the purpose of accepting from the Wallaces upon their death a 550-acre farm, named the Cambus-Kenneth Farm, located on Highway 127 in Boyle County at the outskirts of Danville. Mr and Mrs Wallace have agreed to devise the Farm to the Foundation in order to pursue future charitable and educational purposes. Also, the Foundation shall preserve the historic buildings located on the Farm.

The Cambus-Kenneth Farm was at one time owned by the pioneer physician, Ephraim McDowell, MD. The Farm served as his summer home and was the site of his death. Also, the office building used by Dr McDowell still exists on the Farm and shall be preserved along with the other historic structures on the property. The Farm has belonged to Mrs Wallace's family for many years, most of the time, in fact, since Dr McDowell's death.

The Ephraim McDowell Cambus-Kenneth Foundation was incorporated on May 26, 1988, as a not-for-profit Kentucky corporation. The purposes of the corporation are exclusively for charitable and educational purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and property having special historic significance including, but not limited to, the McDowell House and Apothecary Shop in Danville, Kentucky, and future medically related charitable and educational purposes and any other appropriate charitable and educational purposes as permitted pursuant to federal and state laws. The Farm contains a house which is a fine example of 19th century architecture and is surrounded by buildings which date back to the 18th century, one of which is the earlier-mentioned office of Dr McDowell. It is the intention of the Foundation to preserve these buildings for historic and educational purposes and that the Farm be used for medical research, humanitarian medical activities, and medical educational activities. Any revenues generated by the Farm shall be utilized to support the efforts of the Foundation.

The Ephraim McDowell Cambus-Kenneth Foundation shall be governed by a seven-member Board of Directors. The Board of Directors consists of Kentucky Medical Association Officers; namely, the President, President-Elect, Secretary-Treasurer, and Chairman of the Board of Trustees. In addition, three members of the existing McDowell House Managers Committee serve on the Foundation Board. The present officers of the Foundation are Nelson B. Rue, MD, President; David W. Kinnaird, MD, Vice President; and S. Randolph Scheen, MD, Secretary-Treasurer.

On August 9, 1989, the assets of the former McDowell Memorial Fund were conveyed by the Kentucky Medical Association to the new Ephraim McDowell Cambus-Kenneth Foundation, Inc. This included the three tracts of property containing the McDowell House at 125 South Second Street in Danville, Kentucky, its furnishings, and the Fund's operating accounts. The Internal Revenue Service has recognized the transfer of the assets and has provided a 501(c) (3) tax-exempt status to the Ephraim McDowell Cambus-Kenneth Foundation, Inc.

For practical and legal purposes, the McDowell House Managers Committee will continue operating as a separate standing committee of the Ephraim McDowell Cambus-Kenneth Foundation, and the McDowell House shall continue to operate in the same fashion it has in the past. The creation of the new Foundation enables the entity to exist independently for the purposes of fund raising and providing contributors with the ability to share funds with a charitable corporation.

Mr and Mrs Wallace have indicated an interest in developing the Farm during their lifetimes, as enounced in the Agreement, and would be most receptive to assisting in these efforts. The Officers of the Foundation are in the process of exploring mechanisms in which to bring this about in the near future and would certainly appreciate any input from other members of the Kentucky Medical Association and those individuals who have loyally supported the efforts of the McDowell House in the past.

The official family of KMA has expressed the gratitude and appreciation of the Association for this valuable gift and for the opportunity to preserve this segment of history involving Dr Ephraim McDowell. As the future unfolds, the Foundation will oversee the operation of both of these historic homes of Dr McDowell. *kma*

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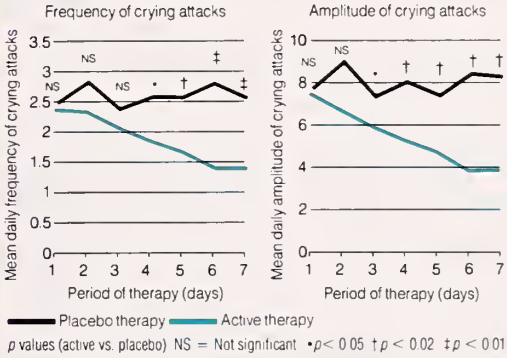

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1. Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic *Practitioner.* 1988,232 508

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PZ24

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Adair

Jesus C. Saidy, MD — IM
Westlake Dr, #104, Columbia 42728
1972, Cebu Institute of Med

Boone

Joseph F. Daugherty, III, MD — IM
141 Manor Ln, Ft Thomas 41075
1974, U of Louisville

Kendell E. Hansen, MD — ANES
6254 Streamside, #68, Burlington 41005
1984, Indiana U

Boyd

Michael D. Nestor, MD — ANES
2138 Hilton Ave, Ashland 41101
1978, U of Kentucky

Christian

Stanley G. Norman, MD — OTO
500 Clinic Dr, Hopkinsville 42240
1965, U of Minnesota

John H. Roark, MD — SU
PO Box 1124, Hopkinsville 42241
1981, U of Arkansas

Fayette

Jean M. Amrien, MD — OPH
241 Shady Ln, Lexington 40503
1983, Eastern Virginia Med School

Richard Mier, MD — PD
UKMC, Pediatrics, Lexington 40536
1973, U of Chicago

Green

Gary Lane Higgason, MD — FP
1003 Arbor View Ct, Lexington 40515
1982, U of Kentucky

Greenup

Cheryl L. Cook, MD — PD
156 Deering Ct, Russell 41169
1985, Marshall U

Hopkins

Thelma A. Gale, MD — ANES
4010 College Dr, Madisonville 42431
1976, Mandalay Institute of Med

James J. Galizia, MD — C
Trover Clinic, Madisonville 42431
1982, New York Med College

Lalchand T. Goyal, MD — C
Trover Clinic, Madisonville 42431
1973, Government Med College, India

Robert M. Groves, MD — C
Trover Clinic, Madisonville 42431
1968, U of Tennessee

Mark M. LeVaughn, MD — PATH
Trover Clinic, Madisonville 42431
1983, U of Tennessee

Hardin

Herbert J. Haynes, MD — R
PO Box 2725, Elizabethtown 42701
1985, U of Kentucky

Khue N. Tran, MD — IM
602 Foxfire Rd, Elizabethtown 42701
1974, Saigon Faculty of Med

Harlan

Jose Nazari, MD — IM
Daniel Boone Clinic, Harlan 40831
1981, Universidad Nacional Autonoma

Jefferson

E. Nigel Harris, MD — IM
2311 Fallsview Rd, Louisville 40207
1976, U of Pennsylvania

Bart M. Olash, MD — IM
217 Pleasantview Ave, Louisville 40206
1983, U of Kentucky

Miguel A. Ossorio, MD — IM
1971 Bardstown Rd, #7, Louisville 40205
1979 Barquisimeto Central U

John R. Pank, MD — ANES
4130 Brentler Rd, Louisville 40241
1980, U of Louisville

Nasiruddin Siddiqui, MD — P
6705 Crossmoor, Louisville 40222
1975, Gandhi Med School

Steven H. Stern, MD — IM
14405 Micawber Way, Louisville 40223
1980, Eastern Virginia Med School

McCracken

John E. Grubbs, MD — N
242 Berger Rd, Paducah 42001
1978, U of Kentucky

Pulaski

Stanton L. Cole, MD — IM
340 Bogle St, Somerset 42501
1982, St. Louis U

New In-Training

UK—
Tammy T. Brown, MD — **FP**

Trover Clinic —
Keith Dinklage, MD — **FP**
Laura Tucker Ellis, MD — **FP**
Cynthia H. Ming, MD — **FP**
Grady H. Pare, MD — **FP**

PEOPLE

Roger Herzig, MD, Marion F. Beard Professor of Hematology at the University of Louisville, has been named director of the James Graham Brown Cancer Center.

The Executive Committee of the U of L Board of Trustees also appointed Dr Herzig as assistant vice president for hospital affairs.

An internationally renowned expert in bone marrow transplantation, Dr Herzig joined the U of L faculty in September 1988 as professor of medicine and director of the Bone Marrow Transplantation Program.

A medical oncologist and hematologist, he served as staff physician in the Department of Hematology and Medical Oncology and directed the Cleveland Clinic Foundation Bone Marrow Transplantation Program prior to coming to U of L. He was also an associate clinical professor of Medicine and Pediatrics at Case Western Reserve University School of Medicine, of which he is a graduate.

Louisville orthopedic surgeon **Thomas R. Lehmann, MD,** was recently recognized by the North American Spine Society for his contribution to clinical research of the spine. Dr Lehmann, who specializes in the treatment of back pain, received the Acromed Award for Spinal Research at the society's annual meeting in Quebec City, Canada.

Dr Lehmann and five other researchers were recognized by the society for a clinical research study they conducted involving a diagnostic technique called discography. Used to determine the source of back pain, discography involves the injection of a dye into a disc of the patient's spinal column. The dye acts as a stimulus to reproduce the patient's back pain, thus helping the surgeon to pinpoint the source of pain and determine the integrity of the disc.

The society reports that prior to this research, surgeons considered discography to be a controversial exam in terms of the validity of its results. Many questioned the reliability of pain reproduction utilizing this technique. By refining the injection and pain assessment techniques however, it is felt the results of Dr Lehmann's study have given new credibility to this diagnostic procedure.

"We believe that this study will stand as a classic contribution to spinal research," Dr Lehmann said. "The study has broken down the barrier to acceptance of a previously controversial examination. And although additional research is needed to further affirm the validity of this examination, it remains an important step forward in improving our ability to diagnose and treat back pain."

UPDATES

Treatment for Chronic Hepatitis C

The University of Louisville reports that doctors have pioneered the first effective therapy for reducing liver damage in victims of hepatitis C, the most common form of hepatitis contracted following a blood transfusion.

Carlo Tamburro, MD, U of L's Liver Research Center director, found the use of recombinant alpha interferon, a genetically engineered protein, produces remission in hepatitis C patients.

Dr Tamburro's research was part of a multicenter study of 166 adults who contracted the disease by exposure to blood or blood products.

Staining Kit Detects Early Signs of AIDS, Gum Disease

University of Louisville researchers report that a cell-staining kit designed to uncover gum disease also has proven effective in detecting AIDS in its early stages.

The researchers wanted a quick, stable silver compound that would show under a microscope the bacteria that cause gum disease. But their process also revealed a fungus in the mouth and lungs of an AIDS patient suffering from infection or lack of immunity.

The staining procedure could become a patient's first indicator of AIDS.

Mammography Screening Going on the Road

University of Louisville doctors soon will be taking to the road with Kentucky's first mobile mammography service.

The university's James Graham Brown Cancer Center recently received a license for a mobile mammography service designed to encourage women to be screened for breast cancer.

The mammography mobile unit should be on the road by early spring, according to Chris Chandler, cancer center administrator. The vehicle will be available on request to physicians, employers, and other interested organizations throughout Jefferson, Bullitt, Henry, Trimble, Oldham, Shelby and Spencer counties.

Since one in 10 American women will develop breast cancer, doctors are looking for ways to make screening more affordable and accessible to women, Chandler said.

Women who are 35 or older, asymptomatic and who have not had a mammogram within the last 12 months can refer themselves to be imaged.

For more information, call Chris Chandler at (502) 588-6905.

FDA Approves Continuous IV Infusion of Tagamet®

The US Food and Drug Administration (FDA) has approved the use of Tagamet® (brand of cimetidine) administered as a continuous intravenous infusion, SmithKline Beecham has announced.

According to SmithKline Beecham, continuous IV infusion of Tagamet controls pH continuously for 24 hours, avoiding peaks and troughs in serum drug concentrations, provides appreciable cost savings to healthcare providers in the hospital pharmacy and the bedside, and is the most convenient and cost-effective method of intravenous administration.

They report the cost savings result primarily from decreased pharmacy and nursing staff time for drug administration, particularly when Tagamet is admixed in total parenteral nutrition (TPN) solutions. This regimen enables a reduction in fluid volume which is desirable in fluid restricted patients. Reducing the number of solutions administered also reduces the potential for error and the risk of infection.

DEATHS

Maurice Kaufmann, MD
Lexington
1907-1989

Maurice Kaufmann, MD, an internist, died December 2, 1989. A 1935 graduate of the University of Louisville School of Medicine, Doctor Kaufmann was a life member of KMA.

Robert F. Brashear, MD
Winchester
1924-1989

Robert F. Brashear, MD, a family practitioner, died December 5, 1989. Dr Brashear was a 1954 graduate of the University of Louisville School of Medicine and had been a member of KMA since 1959.

James L. Becknell, MD
Manchester
1919-1989

James L. Becknell, MD, a general practitioner, died December 23, 1989. Dr Becknell received his medical degree from the University of Louisville in 1952 and had been a member of KMA since 1954.

Choosing a Health Plan

One of the problems with health insurance that physicians continually hear about from their patients is that patients aren't sure what types of coverages they should buy and many times find out after they have purchased a plan that it contains a number of exclusions or benefit limitations.

The Kentucky Medical Association has developed the following guide which we hope will aid individuals in their decision making process regarding health insurance.

Please feel free to remove this page and reproduce it as you feel appropriate. We hope you will find this information useful.

What You Should Ask About Your Health Insurance

- May I choose my physician?
- Is my current physician a member of the plan?
- Will my prescription be paid?
- Are x-rays covered by the plan?
- Are office visits covered? Shots (injections)?
- Can I freely choose to see a specialist or must I be referred by my primary physician?
- Does my primary physician control access to specialty consultation?
- May I choose my hospital?
- Will lab tests be paid?
- Will specialists' services be covered?
- Must I have certain surgical procedures done as an outpatient?
- Will I be screened by medical personnel other than a physician before I see my doctor?
- Do I have easy access to a physician on week nights and weekends?
- Will my health care plan cover me for cost of medical treatment at out-of-town facilities when I travel?
- Will dependents be covered if they reside out-of-state?
- Can I get medical advice from a physician over the telephone during nonoffice hours?
- Am I limited to a certain number of routine care appointments?
- Must I schedule my appointments for routine care far in advance?
- Are any illnesses excluded from the coverage?
- May I request a "second opinion" from an outside physician? If so, will I have to pay for it?
- Will I have to pay a deductible or partial payment?
- When and how often are premium rates subject to change?
- Can I be let go from the plan without advance warning or if I use it too much?
- Do I have to fill out claim forms or will my doctor/hospital do that?
- May I use local physicians and hospitals or must I use those approved by the plan, even if I have to go to another community?
- Is my physician required to obtain permission from the plan before services are rendered?
- Will I be covered for urgent care if it is not rendered in a hospital associated with my health care plan?
- What happens if my physician ceases to be a participant in the plan while I am under his/her care?

Basic Health Care Plans

Fee-for-service is the traditional manner of receiving and paying for medical care. You choose your physician, hospital, and any other medical care you need. You are charged for the care you receive. Often, your care is paid for through a health insurance company whose premiums may be paid by employers. You may pay a deductible (an amount you must pay before your insurance company begins paying for your health care), or a co-payment (you pay a portion of the bill and the insurance company pays the balance).

Health Maintenance Organization (HMO)

An HMO is an organization that provides health care to a group of persons for a pre-determined price. An HMO offers broad coverage at a fixed price. The prepaid fee stays the same for a given period of time, usually one year regardless of the amount of health care used. That fee may be paid by you or, in full or in part by an employer, government or some other sponsor. In some HMOs, services are offered only at specific locations by groups of physicians and other health care personnel. You are required to use the HMO facility and staff to receive medical care.

Independent Practice Association (IPA)

An IPA is a type of HMO. Physicians practice in their office and care for both IPA subscribers and other patients. IPAs are formed by physicians who enter into agreements, usually with an employer group or insurance company, to provide medical services to that group's employees. Since the IPA is an HMO, the patient still must choose a particular group of physicians and a specific medical facility from which to receive medical services.

Preferred Provider Organization (PPO)

A PPO is a group of health care providers who agree to provide services to a specific group of patients (usually employment based groups) at an agreed upon rate.

A Word of Caution

Keep in mind that there are many different types of HMOs, PPOs, IPAs, and other insurance plans being offered today. Each of them has specific restrictions as to the type of care you receive, where you receive it and from whom. Before joining any plan, or before changing your current medical plan, learn as much as possible about the options being offered to you. Ask for written information which outlines the pluses and minuses of each option and read it carefully. Before you make a final decision, discuss the options with your personal physician to make certain that you will be able to receive the care you need under the option you choose.

Finally...

You should realize that many employers choose a plan for their employees. You may not have a choice. However, the information and questions contained in this article will, at the very least, make you more aware of your current health care plan.

Your physician is the best person to help you understand what's happening in medicine today. If you have questions about any subject mentioned here, we encourage you to ask your physician.

Kentucky Medical Association
Spring Schedule
Practice Management Workshops

Medical Necessity for Medicare (9:00 am - 12:00 noon)	Medicare Update (1:00 pm - 4:00 pm)

March 6 - Quality Inn, Covington
March 7 - Executive West, Louisville
Registration fee: $75 each half-day workshop ($135/ both)

TWO HALF-DAY MEDICARE WORKSHOPS - sponsored in conjunction with the Northern Kentucky and Jefferson County medical societies.

How to Get Started in Medical Practice Seminar

March 8-9, 1990
KMA Headquarters Office
Louisville

A two-day practice management workshop designed specifically for physicians entering the practice of medicine or leaving group practices. Topics: Practice alternatives, practice setting and practice-marketing techniques, financing your practice, medical records, patient management, personnel and financial management techniques.

Both series of workshops are being presented by Conomikes Associates, Inc.
For further information or registration, contact the KMA Office (502) 459-9790.
Enrollment is limited in all the workshops.

RATES AND DATA

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FOR SALE, RENT OR LEASE — fully equipped office for one or two doctors, next door to St. Mary and Elizabeth Hospital. No down money needed. Contact: Ben A. Reid, MD, 1602 Gardiner Lane, Louisville, KY 40205.

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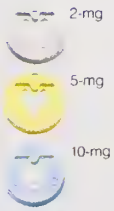

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MARCH

2-3 — 33rd Annual Postgraduate Symposium in Ophthalmology — Corneal Disease, sponsored by The Ohio State University Center for Continuing Medical Education. The conference qualifies for 12.5 hours in Category I of the Physician's Recognition Award of the American Medical Association. Registration fee is $200 for physicians and $100 for non-Ohio State trainees (with a letter from their program director). Contact: Ohio State's Center for Continuing Medical Education (800) 492-4445 or (614) 292-4985; or Lori Elliott, Hospitals Communications (614) 459-3909.

4-9 — 17th Annual Critical Care Medicine Course. Holiday Inn Airport West, Oklahoma City, OK. Accreditation granted by The American Medical Association, The American Academy of Family Physicians, The American Osteopathic Association and The American College of Emergency Physicians. Contact: D. Robert McCaffree, MD, or Dora Lee Smith, Critical Care Medicine Course, University of Oklahoma Health Sciences Center, Room 3 SP 400, PO Box 26901, Oklahoma City, OK 73190; (405) 271-5904.

21-22 — Fifth Annual Geriatric Seminar — "Practical Problems Facing the Practicing Physician." Jewish Hospital, Bottigheimer Auditorium, Louisville, KY; $85 for physicians, $55 for non-physicians. Contact: Terri Graham, RN, Director of Family Practice/Senior Services, Jewish Hospital, 217 E. Chestnut St., Louisville, KY 40202-1886, (502) 587-4685.

30 — "Pancreatitis in the 1990s: Diagnostic and Therapeutic Advances," sponsored by the Department of Surgery at the University of Cincinnati Medical Center. This course has been submitted for 7 CME credit hours. Cost: $75.00. Contact: Aaron S. Fink, M.D.

30-31 — Contemporary Pediatrics for the Practicing Physician. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

30-April 1 — Pediatrics 1990. Marco Island Hilton Hotel, Marco Island, FL. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

APRIL

5-6 — 17th Annual Symposium on Obstetrics & Gynecology. Washington University Medical Center, St. Louis, MO. AMA Category 1 approved. Contact: Cathy Caruso, Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

6-7 — Aggressive Management of Diabetes and Obesity. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

6-7 — Clinical Advances in Treatment of Retina, Vitreous, and Uveal Diseases for the Practicing Ophthalmologist. Marriott's Griffin Gate Resort, Lexington, KY. Contact: Karen Heidorn, Humana Hospital-Lexington, 150 North Eagle Creek Drive, Lexington, KY 40509, (606) 268-3754.

19-21 — The Virginia Society of Otolaryngology — HNS, Radisson Mark Plaza Hotel, Alexandria, VA. Guest speakers: Roy B. Sessions, M.D.; Charles Gross, M.D. Contact: Donna Scott, 4205 Dover Road, Richmond, VA 23221; (804) 353-2721.

21 — Annual Oropharyngeal Cancer Symposium, "The Management of Post Treatment Problems in Head and Neck Cancer Patients," Health Sciences Center Auditorium, Louisville, KY. Co-sponsored by the American Cancer Society, Kentucky Division, the Kentucky Cancer Program, and the James Graham Brown Cancer Center. Contact: Terry Ragsdale (502) 588-0813.

27-28 — Sports Medicine for Physicians. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

MAY

11-12 — Low Back and Sciatic Pain: Evaluation and Treatment; Washington University Medical Center, St. Louis, Mo. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

16-19 — 13th Annual National Conference, "Rural Health! Empowered to Make a Difference," sponsored by The National Rural Health Association. Sheraton New Orleans Hotel, New Orleans, LA. Former U.S. Surgeon General C. Everett Kopp, MD will present the conference's keynote address. Contact: Robert Quick, Communications Director, National Rural Health Association, 301 East Armour Blvd., Suite 420, Kansas City, MO 64111; (816) 756-3140.

19 — Trauma Symposium. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

20-26 — Twenty-First Family Medicine Review — Session II. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

25-27 — Advances in Pediatrics. Marriott's Hilton Head Resort, Hilton Head Island, SC. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd., PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema*. Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension. Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function*. As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions*.)

Surgery/Anesthesia. In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients.

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia. Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension, Patients on Diuretic Therapy. Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents. VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C. There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome: Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers. Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use. Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1%).

HEART FAILURE. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); cardiac arrest, pulmonary embolism and infarction, rhythm disturbances, atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis or cholestatic jaundice, melena, anorexia, dyspepsia, constipation, glossitis, stomatitis.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Herpes zoster, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, tinnitus.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension. In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension*. In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions*.)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment. The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

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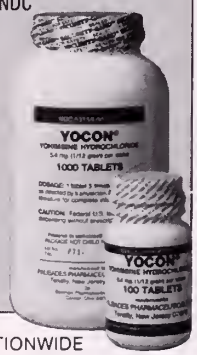

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2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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'It is my feeling that physicians who wish to be called "Doctor" should not be allowed by their own conscience or the collective conscience of the medical community to forget or ignore the health care needs of patients. Physician management and physician review should innately address issues from a patient advocacy position.'

Recent events in my Northern Kentucky community have focused my attention on an issue that is difficult to conceptualize and verbalize. Physicians should not forget their mission to be patient advocates as they address the peripheral issues that now surround health care.

In the past year in our community we have seen efforts by our local hospitals to obtain funding from the state and local governments for uncompensated care provided by the hospitals. But they did not wish to confuse the issue by also requesting funds for preventive care or primary outpatient services delivered in nonhospital settings. Most physicians supported this effort.

We have seen the merging of two of our community hospitals and then the jockeying of the remaining two hospital networks to prove they are the preferred system for patient care. They enlisted the endorsement of physician specialists to endorse specific health care boutiques — laser surgery, wellness centers, women's centers, mammography centers, etc. These same physicians practice the same quality medicine in each hospital.

The managed care companies are proliferating in our area and physicians are serving on numerous committees to do utilization review, credentialing, and quality assessment. Too frequently these physicians are accepting this responsibility without first making certain that the company's process permits thorough peer review.

We have heard Sentinel's pitch to the local medical society and hospital medical staffs to participate in the PRO as peer reviewers. Some of our best physicians have accepted the challenge, but then face the daily dilemma of doing reviews without adequate time or access to the full medical records and pertinent information.

'Organized medicine, the AMA and the KMA, have encouraged in the past and presently continue to encourage physicians to participate in the ongoing development of our diversified health care delivery systems.'

We have seen physicians accept management positions as medical directors of chemical dependence units, sleep laboratories, nursing homes, hospital medical staffs, and HMOs. They manage home health agencies, home IV therapy programs, and reha-

'History is on our side. Patients and their illnesses and injuries have been around forever, physicians have been around for centuries, "managed care" has only been here for several decades. Its shortcomings are becoming more obvious each year.'

bilitation centers. They have become Board of Directors of hospitals and managed care plans. We now even have a physician who is the CEO of a managed care plan. He has avowed to teach physicians how to be good managers so they can function adequately as proponents of the managed care system.

We all realize that health care has now become an industry, a big industry consuming more than 11% of the gross national product. It does not surprise us that there are many ambitious people who are trying to capitalize on the industrialization of patient care. Organized medicine, the AMA and the KMA, have encouraged in the past and presently continue to encourage physicians to participate in the ongoing development of our diversified health care delivery systems.

Each of your physician leaders has worked in some health care related organization independent of his or her affiliation with the KMA. I have worked as a member of the Board of Directors of an HMO, an IPA, and a PPO. I have served as a medical director of a nursing home, and chaired utilization committees, credentials committees, and quality assessment committees of HMOs, PPOs, nursing homes, and hospitals. My disillusionment with my colleagues and other fellow physicians is not with their participation in the process of industrializing health care but in how often I see their efforts overtly or covertly discard the patient advocacy position.

It is my feeling that physicians who wish to be called "Doctor" should not be allowed by their own conscience or the collective conscience of the medical community to forget or ignore the health care needs of patients. Physician management and physician review should innately address issues from a patient advocacy position. Their decision-making processes should be imbued with a philosophy of compassion for the patient. When physicians are sitting on these health related boards and committees, when they are performing peer review activities, they are practicing medicine and should be held to the same standards of patient care (advocacy) as they are when they are seeing patients in their office.

Too many physicians are adopting business practices and procedures at the expense of their medical ethics. Business and medicine are not incompatible, but physicians must remember business people do not and cannot take care of patients. They do not have the personal responsibility for taking care of the sick or injured.

'The managed care companies are proliferating in our area and physicians are serving on numerous committees to do utilization review, credentialing, and quality assessment. Too frequently these physicians are accepting this responsibility without first making certain that the company's process permits thorough peer review.'

'Physicians should not forget their mission to be patient advocates as they address the peripheral issues that now surround health care.'

They will never be fortunate enough to feel the inner warmth of being a "Doctor." Don't expect them to understand your position of patient advocacy. Please, do not succumb to the temptation to be a health care "businessman" or "businesswoman."

Be a physician, a "Doctor," who is working cooperatively in this turbulent time of the industrialization of patient care. History is on our side. Patients and their illnesses and injuries have been around forever, physicians have been around for centuries, "managed care" has only been here for several decades. Its shortcomings are becoming more obvious each year. If the health care entrepreneurs will let us help them, we should be available; but we cannot, and should not, sacrifice our principles and ethics to facilitate their plans.

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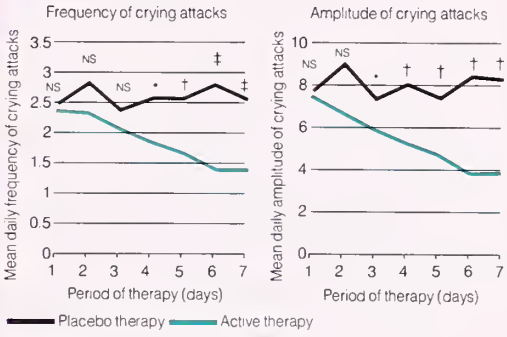

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Resource Based Relative Value Scale — An Update December 1989 —

A report by AMA Alternate Delegate Robert R. Goodin, MD

This report is an attempt to update physicians on the current status of the Resource Based Relative Value Scale (RBRVS) as of December 1989 and is based on information presented at the American Medical Association interim meeting in Honolulu December 3-6, 1989. Since the Harvard Study of an RBRVS was begun in 1985 and endorsed by Medicare officials, and also participated in by the American Medical Association, it has been clear that physician payment reform was an inevitable fact. In December 1988, the American Medical Association endorsed the RBRVS concept with refinements as a means of more equitable distribution of physician payment with increased emphasis on cognitive medicine and decreased emphasis on technologic and procedure medicine. Congress had appointed a physician payment review commission (PPRC) to oversee physician payment reform. The current RBRVS is a product of both the Harvard work and PPRC revisions.

Although physician payment reform is an inevitable fact, it is quite clear that the American Medical Association has been highly effective in altering the recently passed legislation to benefit both patients and physicians. Through very extensive lobbying efforts led by Executive Vice President James H. Sammons, a compromise package was ultimately passed and will be reviewed below. The most essential points of this compromise package were:

1. Defeat of the expenditure targets concept that was pushed for by US Representative Fortney Stark
2. Preservation of balance billing
3. No mandatory assignment of Medicare payments

It is clear that Congress now considers the cost of medical care to be its number one concern, even more important economically than either defense spending or spending for education.

Following is a brief summary of the expected features of the new Resource Based Value Scale payment system that was approved by Congress:

1. A five year phase-in of a Resource Based Medicare fee schedule would begin January 1, 1992. In 1992 fees would be raised or lowered by up to 15% to bring price closer to the RBRVS fee. In succeeding years, the fee would be based increasingly on the RBRVS with a 50-50 split by 1995 and then in 1996 fees would be based completely on the RBRVS.
2. Under the new RBRVS system, geographic adjustments would be made to reflect primarily practice cost and an additional one-fourth adjustment for cost of living. The American Medical Association had fought for geographic adjustments to reflect only practice costs, since such a system would be most favorable to rural primary care physicians.
3. The resource-based relative values would be revised every five years.
4. Fees for non-participating physicians will be set at 95% of fees for participating physicians and ultimately there will be a limit to balance billing by non-participating physicians to a maximum of 115% of the participating physician fee. This adjustment would be phased in over a three-year period.
5. As of April 1, 1990, physicians will be required to accept assignment on claims of only Medicare patients *whose co-payments and premiums are picked up by Medicaid.*
6. As of September 1, 1990, physicians will be required to file all Medicare patients' claims, including those of non-assigned services at no charge to the patient.
7. The compromise legislation would create Medicare Volume Performance Standards (MVPS) which Congress will use as a guideline in determining future fee updates. This is clearly the most controversial provision in the measure, which is intended to bring down the rate of growth in Medicare spending for physician services. The MVPS is a compromise replacement for the expenditure targets and is viewed to be clearly a victory for the AMA. MVPS is designed as a measure of volume use of services in Medicare patients and is to be used only as advisory by the Congress and not as a mandatory directive for fee adjustments. Unlike ETs, the MVPS cannot cause payment roll-backs. Importantly the MVPS does require the Secretary of HHS to consider factors in the growth in expenses

for patient care such as *patient demand, new technology, and the aging and growth of the Medicare population.* Ultimately, MVPS would then be used along with the Medicare economic index as a means of adjusting Medicare payments. Annual growth cannot be less than the Medicare economic index minus 3% after 1995.

8. There will be no specialty differentials in payment for identical services.

. . . The American Medical Association has been highly effective in altering the recently passed legislation to benefit both patients and physicians.

It is clear that Congress now considers the cost of medical care to be its number one concern, even more important economically than either defense spending or spending for education. In view of the concern which is certainly important, the American Medical Association has developed its concept of the best possible American health care system. The belief is that our country is not prepared to endure a national health program such as the Canadian or British health care systems and that a better program for quality health care at an affordable cost is possible. The most critical features of such a program to strengthen the American health care system would include:

1. Medicaid reform to provide medical care to all of the poor, instead of only the 40% now receiving it through Medicaid.
2. Establish state risk pools to provide access to insurance coverage for persons between 100% and 200% of the poverty line with premium assistance for those between 100% and 150%.
3. Create a Medicare commission to develop reforms that would ensure continued health care access by older persons.
4. Develop a longterm care financing system encouraging public and private partnerships.
5. Increase employer provision of health care benefits.
6. Promote the development of practice parameters throughout the health care system to help deal with health care cost problems in a logical fashion. At present some 300 practice parameters have been developed by medical specialty societies and other organizations. These have led to saving hundreds of millions of dollars. At present 25 medical specialty societies are involved in developing practice parameters with an additional 10 societies becoming involved for the first time. It is likely that practice parameters will be essential to the future of our profession if we are to maintain high quality health care at an affordable cost.
7. Voluntary care.

. . . 300 practice parameters have been developed. . . . These have led to saving hundreds of millions of dollars.

The American Medical Association appears to be in an excellent position to play a strong role in the continued development of the Resource Based Relative Value Scale reimbursement system. The hope is that practice parameters can be coordinated with the developments in the RBRVS to ensure that high quality health care will be maintained in the efforts to reduce the cost of health care. It is expected that Congress will be assisting in the funding for development of practice parameters that can be relative as well as practical enough to apply in daily practice.

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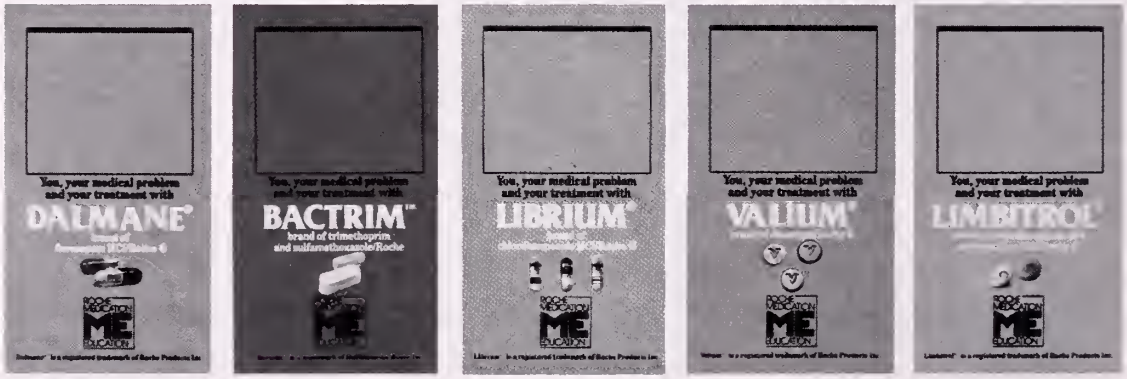

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The 1989 Kentucky Hospital Smoking Policy Survey

John R. Thompson, MD; Barbara A. Phillips, MD; John Cabelka

Kentucky leads the nation in percentage of smokers (32.5%), years of potential life lost due to smoking-related illness, and burley tobacco production. In view of this, we sought to determine current practice regarding smoking policies in Kentucky hospitals. Acute care and psychiatric hospitals were identified through the 1988 Kentucky Hospital Association Directory and the Paired Community Laboratory System. One hundred seven institutions were sent standardized questionnaires. An additional 16 hospitals were contacted by phone only. All mail and telephone surveys were directed towards the institution's president, administrative director, or CEO. Eighty-one (75.7%) of those contacted by mail responded to the survey. The 26 non-responding institutions were then contacted through a telephone survey. Thus, 100% of acute care hospitals in Kentucky participated in the survey. Of the 123 institutions surveyed, 110 (89.4%) have some type of smoking policy. Of those 110 hospitals with smoking policies, only 6 totally prohibited smoking on the premises. The 13 hospitals without any form of policy were queried about future plans for smoking policies. Of these, only 4 had no plans to work on a hospital smoking policy. Of the 123 hospitals surveyed, 100 do not sell tobacco products. There were no statistically significant differences between the numbers of beds, average length of stay, occupancy rate, or county populations in Kentucky hospitals that do not sell tobacco versus those hospitals that do sell tobacco. Indices of tobacco production in the geographic location of the hospital did not correlate with the likelihood of the hospital's selling tobacco or restricting smoking. We conclude that the vast majority (89.4%) of Kentucky hospitals restrict smoking in some way, although only 6 (4.8%) are totally smoke free. Tobacco products are still sold in 18.7% of Kentucky's hospitals. These data help provide a baseline to assess the impact of KMA and AMA resolutions for smoke-free hospitals. Supported by a Preventive Pulmonary Academic Award from the National Institutes of Health.

A majority of Kentucky hospitals have established smoking policies. It is very important to note, however, that only a very small minority (6/123) were totally smoke free as of 1989.

From the University of Kentucky College of Medicine, Lexington, KY 40536-0084. *Supported in part by a Preventive Pulmonary Academic Award, National Institutes of Health.*

Introduction

In its 1989 session, the American Medical Association adopted Resolution 29, which reads as follows:

> Resolved that the American Medical Association reaffirm its established policy regarding a smoke-free society with the addition of the following: (1) advocate that all American hospitals ban tobacco use by January 1, 1991; (2) urge physicians to prohibit smoking and use of tobacco in their offices; (3) work toward legislation and policies to promote a ban on smoking and use of tobacco products in hospitals, health care institutions, and educational institutions (including medical schools; (4) develop and disseminate model language to administrators of American hospitals and membership of the hospital medical staff section of the AMA to emphasize and facilitate the importance of a smoke-free hospital environment.

This explicit resolution clearly states the official stand of organized medicine regarding smoking in hospitals and sets out specific guidelines to accomplish smoke-free hospitals.

Because of Kentucky's economic dependence on tobacco, restrictions on tobacco use in

Kentucky have lagged behind those in other states. Nevertheless, the Kentucky Medical Association also endorsed Resolution J, calling for smoke-free Kentucky hospitals, in its 1989 session. In view of these resolutions of the AMA and KMA, we sought to determine the current practice regarding smoking policies in Kentucky hospitals, in order to begin monitoring changes over time.

Kentucky leads the nation in percentage of smokers (32.5%), years of potential life lost due to smoking related illnesses and smoking attributable mortality, is third in death rate from lung cancer, and sixth in the death rate from chronic obstructive lung disease.

Methods

All acute care and psychiatric hospitals were identified through the 1988 Kentucky Hospital Association Directory[1] and the Paired Community Laboratory System.[2] One hundred seven institutions thus identified were sent standardized questionnaires. An additional 16 hospitals were contacted by telephone only. Mail and telephone surveys were directed toward the institution's president, administrative director, or chief executive officer. Eighty-one (75.7%) of those contacted by mail and 100% of those contacted by telephone responded to the survey. The 26 institutions that did not respond to the mailed survey were then contacted through a telephone survey. Thus, 100% of acute care hospitals in Kentucky participated in this survey.

Respondents to the survey were asked the following questions:

1. Does your hospital have a smoking policy?
YES____ NO____

If yes, how long has that policy been in force? ____

If yes, please attach a copy of that smoking policy.

If yes, does the policy prohibit smoking by:
—patients in their rooms? *YES____ NO____*
—patients anywhere in the hospital? *YES____ NO____*
—employees? *YES____ NO____*
—visitors? *YES____ NO____*

If yes, are there specific areas set aside for employees, visitors, or patients to smoke? *YES____ NO____*

If no, is your hospital working on a smoking policy? *YES____ NO____*

If no, what are the reasons most commonly given by administration or staff about not implementing such a policy? _____

2. Are tobacco products sold in your hospital? *YES____ NO____*

3. Please write any additional comments here:

Data was collected and analyzed on computers using SuperStat[3] and the Paired Community Laboratory System.[2] Descriptive hospital data was obtained from the 1988 Kentucky Hospital Association Directory. Separate analyses were performed for all hospitals and for acute care hospitals.

Indices of tobacco production in the geographic location of the hospital did not correlate with the likelihood of the hospital's selling tobacco or restricting smoking.

Number of beds, number of admissions, average daily census, average daily occupancy rate, average length of stay, and expenses per admission were calculated and compared for each group of hospitals using the paired T-test. Hospital ownership and available services (such as cardiac intensive care unit, open heart surgery facilities, cardiac catheterization, and hospice) were compared using the proportional Z test and Chi Square.

County demographics were obtained from the 1980 census data. County population, unemployment rates, income levels, and educational rates were analyzed using the paired T-test. County spe-

cific tobacco production was compared using proportional Z test and Chi Square.

Results

Eighty-one (75.5%) of the hospitals contacted by mail responded to the survey. There was no difference between the proportion of hospitals restricting smoking or selling tobacco and the likelihood of returning the survey. Also, there were no differences between the hospital size, census, occupancy rate, average length of stay, or ownership of the hospitals between responders and non-responders. However, hospitals that had cardiac intensive care units and cardiac catheterization facilities were more apt to respond to the survey ($p < 0.05$).

Of the 123 institutions surveyed, 110 (89.4%) had some type of smoking policy. Of those 110 hospitals with smoking policies, however, only 6 totally prohibited smoking on the premises. Prohibition of smoking by patients, employees, and visitors varied from place to place within hospitals; data is presented in Table 1.

The 13 Kentucky hospitals without any form of smoking policy were queried about future plans for smoking policies. Of these, only 4 had no plans to work on a hospital smoking policy, citing reasons such as, "other problems are bigger" and that they had received "no complaints" regarding the lack of a smoking policy.

Of the 123 hospitals surveyed, 100 did not sell tobacco products. There were no statistically significant differences between the numbers of beds, average length of stay, occupancy rate, or county populations in Kentucky hospitals which do not sell tobacco vs those which do sell tobacco products. Similarly, indices of tobacco production in the geographic location of the hospital did not correlate with the likelihood of the hospital's selling tobacco or restricting smoking.

Those hospitals with smoking policies were more apt to have a hospice program and to provide open heart surgery services ($p < 0.05$). However, there were no differences between hospitals with and without policies regarding cardiac catheterization facilities or a cardiac intensive care unit. There were also no differences between the type services offered between hospitals selling tobacco products and those not selling tobacco products.

Hospitals within non-metropolitan counties were just as likely to have policies and to sell tobacco as those in metropolitan counties. Similarly, hospitals in Appalachia were just as likely to have policies and sell tobacco as those in non-Appalachian counties.

Table 1.

	Total Prohibition	Restriction to Specified Area(s)	No Restrictions
Patient in Room	36	32	42
Patient-Anyplace	6	96	8
Employees	7	98	5
Visitors	10	94	6

Kentucky leads the nation in burley tobacco production and its economic impact has definitely impeded initiatives to restrict the use of tobacco in the state.

There was no difference between county tobacco production and the likelihood of hospitals within that county selling tobacco products. Direct comparison of high tobacco producing counties to low tobacco producing counties revealed that hospitals in high tobacco growth counties were more likely to have a smoking policy ($p < 0.05$). However, these differences disappeared when metropolitan counties were eliminated from the analysis.

Likewise, there was no difference between the likelihood of a hospital having a smoking policy or selling tobacco between counties of large and small rural populations, high and low poverty levels, or high and low educational levels. Hospitals in counties with a higher unemployment rate were more apt to have a smoking policy, but there was no difference in the unemployment rate between those hospitals selling tobacco products and those not selling tobacco products.

Discussion

Kentucky leads the nation in burley tobacco production and its economic impact has definitely impeded initiatives to restrict the use of tobacco in the state. Kentucky leads the nation in percentage of smokers (32.5%),[4] years of potential life lost due to smoking related illnesses and smoking attributable mortality,[5] is third in death rate from lung cancer, and sixth in the death rate from chronic obstructive lung disease. However, a majority of Kentucky hospitals have established smoking policies. It is very important to note, however, that only a very small minority (6/123) were totally smoke free as of 1989. Because of the AMA and KMA's initiative in the area of hospital smoking policy, we expect that Kentucky hospitals will establish and strengthen smoking policies. Data presented here help to provide a baseline to assess the impact of the KMA and AMA resolutions on smoke-free hospitals.

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Intracranial Tuberculoma

David A. Dao, MD; Patricia W. Lee, MD; Thomas M. Roy, MD

In North America, central nervous system involvement by tuberculosis is uncommon. This patient review describes the clinical and radiological features of this unusual neurologic lesion. Special emphasis is given to the methods of arriving at the correct diagnosis, to the efficacy of combination antituberculous therapy, and to the possibility of paradoxical expansion of these lesions during the course of successful treatment.

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Introduction

Intracranial tuberculoma may result from the hematogenous spread of *Mycobacterium tuberculosis* from a more distant focus of infection. Fortunately, the incidence of central nervous system (CNS) tuberculoma in patients with active tuberculosis in the United States is rare and estimated at less than 0.7%.[1]

Proper assessment of the patient's clinical presentation coupled with the application of modern neuroimaging techniques is essential in distinguishing CNS tuberculoma from more commonly occurring space occupying lesions. Early diagnosis is imperative since prompt therapy with combination antituberculous agents make this lesion potentially curable and significantly decreases the chance of permanent neurologic sequelae and mortality.[2]

We report a patient with tuberculomas of the brain and the brain stem who initially demonstrated clinical and radiographic improvement when treated with the recommended combination of antituberculous agents — isoniazid, rifampin, and ethambutol.[3,4] The patient experienced radiographically proven reexpansion of his tuberculomas with neurologic deterioration when ethambutol was eliminated from his treatment regimen. This requirement for ethambutol is unusual and provides the basis for a review of the evaluation and treatment of CNS tuberculomas.

Case Report

T.P., a 75-year-old white male, presented with a one month history of double vision, mild headache, difficulty with fine motor movement of his right hand and fingers, generalized weakness, and low grade fever. He also noted numbness and tingling at the left angle of his mouth, which made speaking difficult. His wife confirmed that his voice and speech pattern had changed over the two weeks prior to admission. The patient denied night sweats or weight loss.

During the admission physical examination, the patient was noted to have slurred speech. He was awake and oriented, but lethargic. His vital signs were normal except for an oral temperature of 99.0°F. A left lateral rectus muscle weakness was noted during the ocular examination. Fundoscopic examination was normal. He was found to have left facial weakness with loss of his normal nasolabial fold, but his tongue and uvula moved in the normal midline position. The patient had some difficulty in performing the finger-to-nose maneuver with both hands, but the drift was more pronounced on the right side. He also demonstrated difficulty in performing rapid alternating movements with the right hand. Although the patient's vibratory sensation was diminished symmetrically, no sensory loss could be documented. The remainder of the physical examination was normal.

The admitting laboratory work, which included measurements of renal and liver function, serum electrolytes, complete blood count, urinalysis, and coagulation parameters, was normal. The Mantoux tuberculin skin test using the standard 5 IU was nonreactive, as were the candida, mumps, and histoplasmin skin tests.

The admission chest radiograph was interpreted as having bilateral apical infiltrates and a 2.5 cm parenchymal density in the region of the right middle lobe. CT scan of the head documented the presence of two lesions in the left parietal lobe, and single lesions in the right parietal lobe, left frontal lobe, left cerebellum, and the brain stem. The lesions showed ring enhancement with a dark center, measured approximately 1 cm in diameter, and were surrounded by edema.

The initial provisional diagnosis was bronchogenic neoplasm with multiple brain metastases. In order to establish the histologic profile and primary focus of the malignancy, flexible fiberoptic bronchoscopy with biopsy and bronchoalveolar lavage was performed. Diffuse inflammation was visualized bilaterally, but no endobronchial lesions were seen. The specimens were negative for malignant cells, but acid fast

bacilli were recovered from the bronchial washings.

Because the lesions in the brain and brain stem were surrounded by edema, there was concern abut potential herniation. Lumbar puncture and examination of the cerebrospinal fluid were not performed.

The patient was started on combination antituberculous therapy which included isoniazid 300 mg/day, rifampin 600 mg/day, ethambutol 1200 mg/day, and pyridoxine 50 mg/day. To this regimen, dexamethasone 4 mg/day was added to reduce cerebral edema and decrease the potential of developing hydrocephalus.

The diagnosis of tuberculosis was subsequently confirmed when the acid fast bacillus was identified as *M tuberculosis* by the Kentucky Department of Human Resources Bureau for Health Services laboratory. On drug susceptibility tests, the organism proved to be sensitive to all of the usual anti-tuberculous agents.

At the time of discharge from the hospital, the patient had received two weeks of antituberculous therapy and his clinical status was improving. His slurred speech had disappeared, and his left facial and right extremity weakness were minimal. His double vision had resolved.

One month after discharge, the patient was able to return to part-time work as a barber. A repeat CT scan was performed and was interpreted as showing almost complete resolution of the parietal and brain stem lesions, with little change in the left frontal and left cerebellar lesions.

Three months after discharge, the ethambutol was discontinued and maintenance therapy was continued with isoniazid, rifampin, pyridoxine, and decadron. Three weeks after stopping ethambutol, the patient became confused, developed diplopia, and was readmitted to the hospital after experiencing a right-sided, tonic-clonic seizure. CT scan of the brain now showed recurrence of the tuberculomas in the right and left parietal areas as well as in the right midbrain. The surrounding edema was also present. Dilantin 300 mg/day was started and ethambutol was restarted at 1200 mg/day. The patient gradually improved over the next three weeks.

The patient continued to do well without further seizures. A fourth CT scan was performed six months after the original study. This CT scan showed complete resolution of the abnormalities noted on the previous scans. The chest radiograph at this time showed marked improvement in the infiltrates originally present, with some residual markings in the region of the right middle lobe.

The patient completed 18 months of treatment with three antituberculous agents and has done well since their discontinuance.

Discussion

Hematogenous seeding of the central nervous system (CNS) from a distant focus of tuberculosis infection may result in the formation of intracranial tuberculomas.[5] The frequent localization of tuberculomas to the cerebral and cerebellar hemispheres is a reflection of the high blood supply to these areas. In adults these space occupying lesions are usually supratentorial, but occur infratentorially more commonly in children. Rarely, tuberculomas are also found in the brain stem.[2] Multiple tuberculomas occur in 10% to 30% of cases.[6] Although intracranial tuberculoma has been an unusual neurologic disorder in the United States due to the national decline in new active cases of tuberculosis, there is some evidence that the incidence may be increasing with the large influxes of refugees from areas where tuberculosis is epidemic[7,8] and with the increase in active pulmonary tuberculosis in patients suffering from the acquired immunodeficiency syndrome (AIDS).[9]

The clinician is faced with the responsibility of making the correct diagnosis promptly, as the patient's prognosis depends heavily upon the timing of therapy. The highest mortality associated with CNS tuberculomas occurs in patients who are diagnosed and treated late in their course. On the other hand, most patients do well if medical therapy is begun early.[10]

A high index of suspicion is required to recognize tuberculoma as the cause of the symptoms associated with a CNS space occupying lesion. Most patients will have complaints of either headache, diplopia, or limb weakness which have evolved during a one-week to three-month interval. In one study, all patients presented with some combination of focal neurologic signs that consisted of cranial nerve dysfunction, cerebellar ataxia, and varying degrees of motor or sensory deficits.[2] Fever and malaise may accompany the neurologic symptoms in approximately 40% of patients. The majority of patients will present with documented weight loss and will have a significant amount of induration to the intermediate strength PPD administered by the Mantoux tu-

berculin skin test. It should be emphasized that a tuberculin reaction of greater than 5 mm induration should be considered indicative of tuberculous infection in an HIV-infected person.[11] Approximately 50% of patients with intracranial tuberculoma will show no other evidence of tuberculosis outside of the central nervous system.[12]

Chest radiographs are sometimes helpful in suggesting the association of the CNS lesion with tuberculosis, however, certain limitations exist. In the immunologically competent patient with tuberculoma, the chest x-ray will have a pattern consistent with reactivation tuberculosis. The classic presentation will be upper lobe infiltrates with apical involvement and cavitation. In the AIDS patient, the chest roentgenograph will be more nonspecific. Patients may present with infiltrates in any lung zone, often with associated mediastinal and/or hilar lymphadenopathy.[13]

As with any case of tuberculosis, the collection of a variety of specimens for mycobacterial stains and culture may be required to confirm the diagnosis. When reasonable and indicated, the examination of respiratory secretions, bronchial washings, gastric lavage, urine, stool, pleural fluid, bone marrow, and cerebrospinal fluid (CSF) should be conducted. Evaluation of the CSF from a patient with a CNS tuberculoma is frequently unrewarding. Typically the protein is elevated, but the glucose values are surprisingly normal. Attempts to establish immunoglobulin profiles for brain stem tuberculomas have not been uniformly accepted. Stains and culture of the CSF for acid fast bacilli (AFB) have not shown much utility. The likelihood of a positive smear for AFB in the CSF of a patient with an intracranial tuberculoma is only 10%.[2] The low sensitivity of these tests on the CSF make it difficult for the clinician to distinguish tuberculoma from such conditions as glioma, which are far more common. Likewise, negative smears of CSF for AFB cannot be used to eliminate the diagnosis of tuberculoma. Although not specific enough to make the diagnosis of tuberculosis, the presence of increased white blood cells in the CSF is helpful in suggesting an infectious etiology.

Faced with this diagnostic dilemma, the clinician will find computerized tomography (CT) of the head most helpful. On nonenhanced CT scans, CNS tuberculomas are usually isodense or only moderately hyperdense and may be surrounded by edema.[2,14] Almost all tuberculomas will show enhancement after the injection of contrast material. Two patterns of lesion enhancement have been described, and the type that occurs probably depends on the stage of evolution of the tuberculoma. The first is "ring-enhancing" and may be found in association with a central calcification called a "target sign" which is fairly characteristic of intracranial tuberculoma. The second pattern is the "nodular enhancing" type in which the lesions are small and irregular in shape with speckled unenhanced areas.[14] The integration of the data from the patient's clinical presentation with the neuroimaging by CT scan is generally successful in suggesting the correct diagnosis.

Nuclear magnetic resonance imaging (MRI) has recently been shown to be superior to CT in the diagnosis of brain stem pathologic conditions because the MRI image is not affected by the bony structures at the base of the skull. Unfortunately, only one patient with a brain stem tuberculoma has been studied with MRI and reported at the time this manuscript was prepared.[6] The role of MRI in differentiating tuberculomas from other CNS lesions remains to be determined.[2]

A recurring theme in the literature concerning intracranial tuberculomas is the admonishment to initiate antituberculous therapy when the index of suspicion for CNS tuberculoma is high, even in the absence of microbiologic confirmation.[8] As a general rule, the patient's prognosis is better with modern antituberculous medication than with surgery.[15] Although there is no universal consensus regarding the optimal combination of antituberculous agents or the duration of therapy, most authorities agree that isoniazid is the cornerstone of therapy for tuberculoma because of its bactericidal properties and its ability to penetrate into the CNS.[3] The usual recommendations suggest starting therapy with isoniazid in combination with rifampin and either ethambutol or streptomycin for the first three months or until a clinical response is observed. Therapy is then continued with two drugs (isoniazid and rifampin) for a total of 18 months or with a three drug combination for 12 months.[3,4] A favorable outcome is expected when medical therapy is started early.

Surgery is reserved for patients with brain stem tuberculoma who require shunting for hydrocephalus or in the event that a stereotactic biopsy of the lesion is desired to justify the risks of empiric treatment.[16]

Our patient demonstrated clinical resolution of his diplopia and upper extremity weakness

within two weeks of being started on the combination of isoniazid, rifampin, and ethambutol. However, when ethambutol was discontinued, his neurologic signs and symptoms recurred. Reexpansion of the tuberculomas on CT scan was confirmed. Paradoxical expansion of intracranial tuberculoma during the course of successful treatment has been reported previously.[17] This transient phenomenon is thought to occur as a result of immunologic mechanisms and occurs at a time when the patient is improving clinically and does not require a change of therapy. Deterioration of neurologic status has not previously been associated with the paradoxical expansion of the tuberculoma unless bleeding has occurred within the lesion.[2] The rapid clinical and radiographic improvement in our patient after reinstituting ethambutol suggests that bleeding was not the cause of expansion of the tuberculomas or the deterioration in his neurologic status. It is our opinion that ethambutol was an essential antituberculous medication in this patient's regimen.

In summary, intracranial tuberculoma remains a potentially curable but extremely rare condition that must be differentiated from other space occupying lesions of the CNS. While the diagnosis remains difficult, integration of the data from the clinical presentation, tuberculin skin testing, CSF analysis, chest radiograph, and CT scan of the head provide an accurate diagnosis in most patients. Because any delay in starting treatment usually leads to increased morbidity and mortality, an empiric trial of antituberculous drugs is justified when intracranial tuberculoma is suspected. Based on our case presentation, ethambutol appears to be a worthwhile addition to the combination of antituberculous medications selected.

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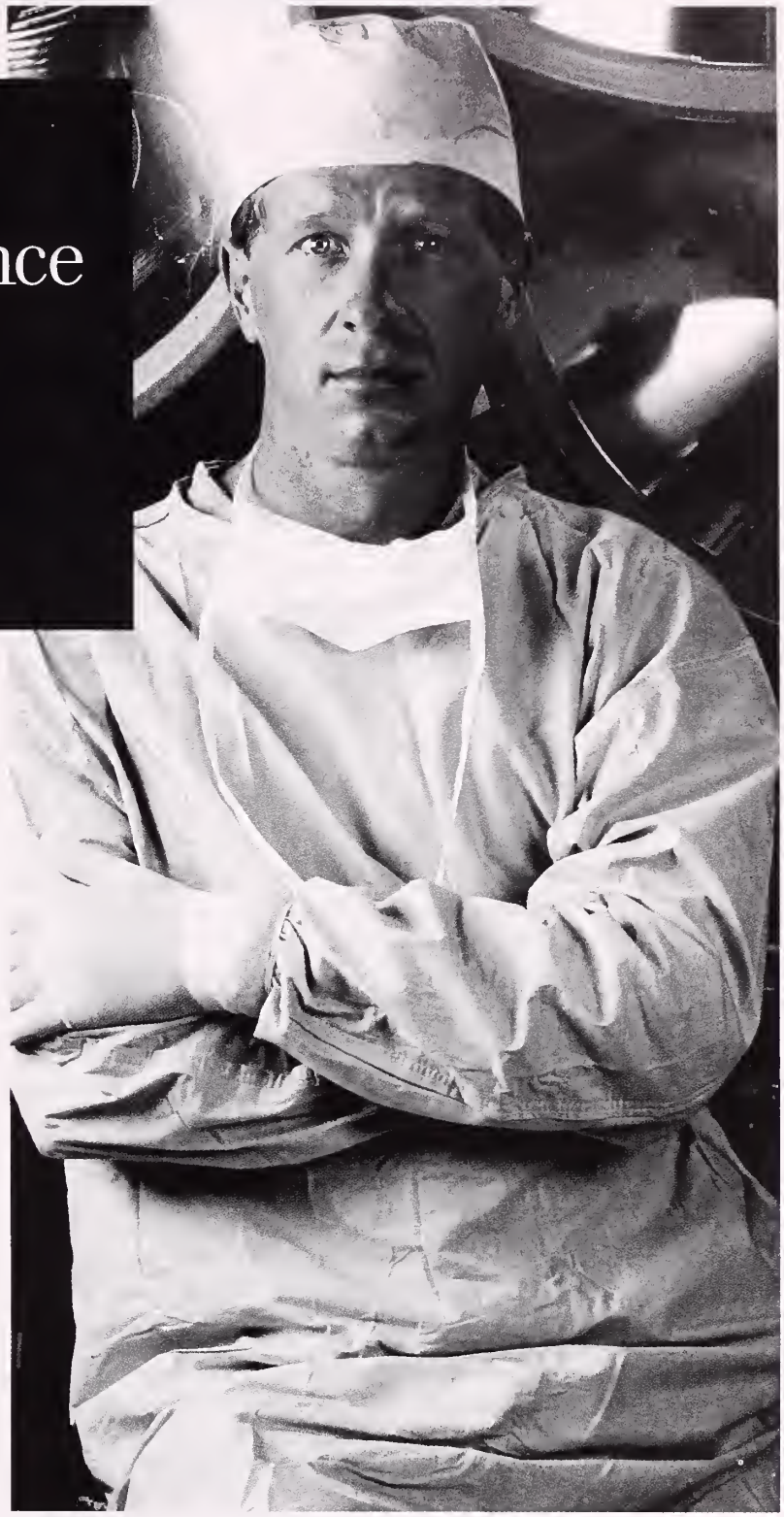

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Compartment Syndrome of the Upper Extremity

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Introduction

Compartment syndrome is ischemia to muscles and nerves secondary to increased pressure in the muscular compartment. According to Hayden, in a community hospital receiving 2000 emergency room admissions, one is likely to diagnose between six and eight compartment syndromes.[1] Compartment syndrome is a medical emergency, and the patient's outcome is a function of the duration of the tissue ischemia. Below is a case presentation of a typical case of this syndrome in the upper extremity.

Case

A 35-year-old male presented to the emergency department with a history of having been in a drunken stupor and awaking with complaints of right upper extremity pain and flexion contracture of the fingers. On physical examination, he was noted to have diffuse blistering of the volar surfaces of the hand and forearm. The right hand was held with the proximal interphalangeal joints in full flexion. The fingers could not be fully extended passively without complaints of pain. Measurement of compartmental pressures showed the forearm extensor compartment and the intrinsic compartments of the hand to have pressures greater than 35 mmHg (normal 0-10). He was taken to the operating room where fasciotomies of the extensor (dorsal) compartment of the forearm and of the right hand were performed. Direct muscle observation showed poor contractility and color of the interosseous muscles. Three months after surgery the patient exhibited good return of forearm extensor function with somewhat poor interosseous function. At six months he had full range of motion but continued weakness.

Upper Extremity Compartments

The major compartments of the upper extremity are the volar and dorsal compartments of the forearm and the interosseal compartments of the hand (Fig 1).[2] Compartment syndromes have also been described in the deltoid, biceps, brachialis, and the anconeus muscles.[3]

The volar compartment of the forearm is statistically the most prevalent site of compartment syndrome in the upper extremity.[2] The volar compartment is defined by the antebrachial fascia which extends between the radius and ulna and surrounds the bulk of the forearm flexors. Contained within the compartment are the median and ulnar nerves, the flexor muscles of the wrist and digits, the palmaris longus, flexor carpi radialis, flexor carpi ulnaris, flexor pollicus longus, flexor digitorium profundus and superficialis. The brachial artery and median nerve within this compartment are particularly susceptible to entrapment.[4]

The dorsum of the forearm and the interosseal compartments of the hand are less frequently affected.[5,6] The dorsal compartment lies dorsal to the antebrachial fascia in the forearm. Contained in this compartment are the posterior interosseous nerve and artery, the extensor carpi ulnaris, extensor digitorium communis, extensor carpi radialis brevis, extensor carpi radialis longus, supinator, extensor pollicis longus, abductor pollicis longus, extensor pollicis brevis, extensor indicis and the extensor digiti minimi. In the hand, four fibro-osseous compartments are described: (1) the central compartment containing the flexor tendons; (2) the thenar compartment containing the thumb intrinsic musculature; (3) interosseous compartments defined by the metacarpals; and (4) fascia surrounding the hypothenar musculature.

Etiology

Compartment syndrome may occur in one of two settings: a decrease in compartmental size or an increase in compartmental contents.[7] Causes of decreased compartment volume include closure of fascial defects and excessive traction applied to fractured limbs. Causes of increased compartmental pressures include hemorrhage, an increase in capillary permeability following trauma or ischemia, intense exercise, thermal or electrical damage, or eclampsia.[2] An increased capillary pressure may also be responsible for compartment syndromes. An example of this was recently described in a case of chronic myelogenous leu-

kemia (CML) in which tumor infiltrates disrupted normal interstitial fluid balance resulting in an impairment of lymphatic drainage and subsequent increase in compartmental pressure.[8]

The most common cause of compartment syndrome is trauma, usually associated with fractures, accounting for 45% of all cases in one study.[7] The degree of associated tissue trauma determines the risk for the syndrome, for example, a distal radius fracture in the elderly versus a blast injury. Distal radius fractures are quite common in the elderly and often result from simple falls. The incidence of compartmental syndrome in this age group is small.[9] In a fracture resulting from an exploding truck tire there is a greater incidence of tissue edema from the soft tissue injury. This compartmental edema results in a compromise of tissue perfusion causing more edema and a further increase in compartmental pressure. The net result of this cycle is myonecrosis and nerve compression.[1]

Another perhaps more direct entry into this vicious cycle arises through direct limb compression, as in the case of our patient. Since he was in a drunken stupor for an unknown period of time, it is impossible to gauge how long he had been lying on his right upper extremity. Direct limb compression has been correlated with marked increase in intracompartmental pressure. In the forearms, torso compression produces compartmental pressures between 100 to 225 mmHG. Forearm pressures may approach 75 mmHG upon direct compression from the head. Studies have shown that complete obstruction of tissue perfusion may occur at compartmental pressures above 64 mmHG.[9] The time frame between injury and presence of symptoms may vary from 12 hours to 2 days.[10]

The mechanism of compartmental hypertension following tissue ischemia is slightly different. Prolonged ischemia results in damage to the capillary endothelium and the cellular ionic pumps. When circulation is reestablished, the increased capillary permeability permits intravascular fluid to leak into the interstitium. This leads to elevated compartment pressure, which produces further ischemia. An extremity with six or more hours of ischemia is at high risk for a compartment syndrome.[2]

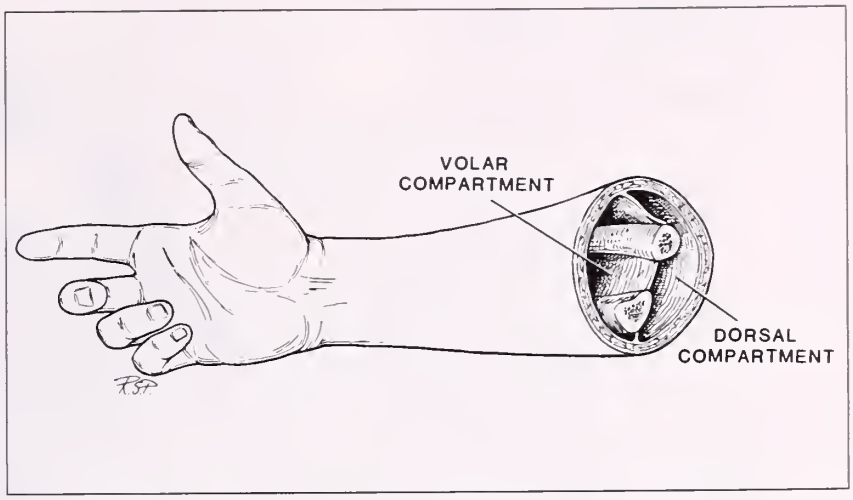

Fig 1-A — The forearm has volar and dorsal compartments. Compartment syndrome is more common in the Volar compartment.

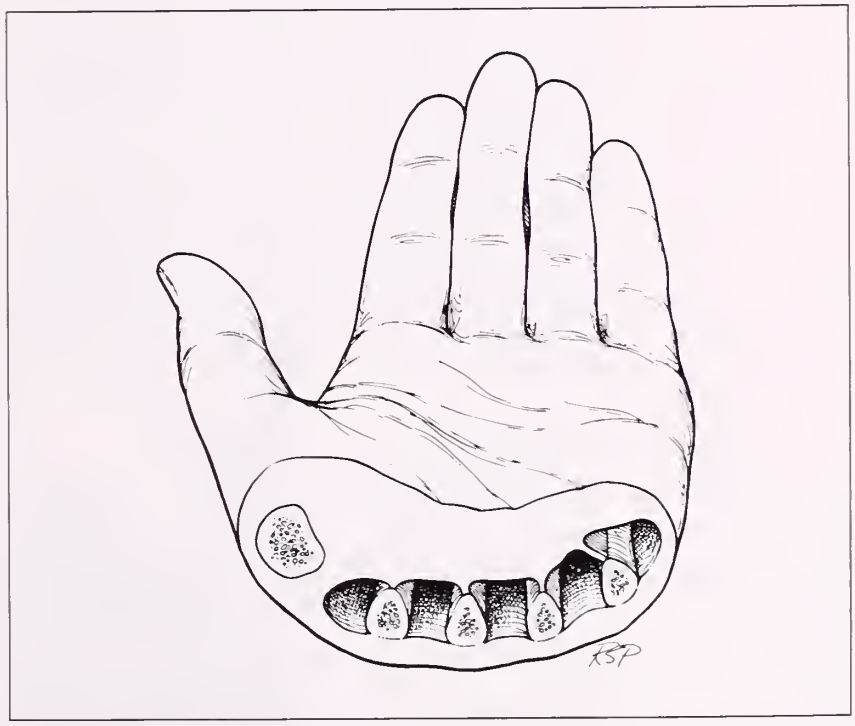

Fig 1-B — The thenar, hypothenar, and interosseal spaces form the compartments of the hand. The carpal tunnel can also be a site of nerve compression.

Clinical Manifestations

Christiansen et al report the following pentad of conditions usually present in this syndrome:

1. increasing pain subsequent to an injury, with pain out of proportion to that injury;
2. weakness of the muscles in the affected compartment;
3. pain on passive stretching of muscles in the compartment;

4. decreased sensation along the sensory distribution of the entrapped nerve;
5. tension, edema, and/or redness over the compartment.[11]

Other findings include the presence of wheals, blebs, or erythematous plaques over the affected area. These areas may deteriorate to full thickness skin loss.[10] The presence of pulses distant to the edematous compartment should not be used to rule out presence of a compartment syndrome, since pulses may be intact with elevated compartment pressures. As nerve ischemia progresses, progressive neurological defects will be seen. Sensory loss is seen as ischemia to the nerve progresses. Generally, motor strength is the last neurological function to be lost.[7] Loss of voluntary muscle function shows a profound level of nerve impairment. Muscle testing should be done by testing the more distally innervated muscles first. Both motion and muscle strength should be tested. With severe weakness the muscle belly should be palpated in order to assess whether contraction is occurring.[12]

Untreated compartment syndrome results in a Volkmann's ischemic contracture, a condition described over 100 years ago and characterized by a progressive contracture of the wrist and finger flexor muscles. This is a result of progressive scar tissue proliferation subsequent to severe myonecrosis.[1]

Management

If the patient has a compartment syndrome, the primary management is referral to a surgeon. If the diagnosis is unclear, the intracompartmental pressure should be measured. One may measure intracompartmental pressure in many ways. A simple reproducible technique was developed by Whitesides et al.[13] This technique involves the use of a mercury manometer, a 20cc syringe, IV tubing, and an 18 gauge needle. Briefly, the pressure is measured by aspirating fluid into the 18 gauge needle, leaving the remainder of the system filled with air. As the meniscus changes from convex to concave upon pressure from the syringe, the pressure reading on the manometer will equal that in the osteofascial compartment.

Mubarak stated that a level of 30 mmHg was sufficient to warrent immediate fasciotomy to decompress the compartment.[14] If the pressures are elevated, but not to a level requiring surgery, the pressures should be remeasured sequentially. Limb elevation in the interim is not recommended since elevation decreases critical arteriolar closing pressure.[10]

In managing a compartment syndrome, one must always bear in mind the systemic manifestations if muscle necrosis occurs. Myonecrosis results in release of myoglobin and subsequent myoglobinuria. This may further progress to acute renal failure. Urinalysis, blood urea nitrogen, creatinine, as well as heme urine dipstick should be carefully monitored. A positive heme on dipstick with no red blood cells found on urinalysis indicates the presence of myoglobin in urine. Myonecrosis also may result in the liberation of large amounts of potassium into the bloodstream. Serum potassium levels should be checked closely to avoid the precipitation of arrhythmias. Use of potassium in intravenous fluids should be restricted.

Compartment syndrome is a dangerous sequela of a soft tissue injury to a limb. Fasciotomy is the only treatment and is an emergency procedure to prevent muscle death and the crippling deformity of Volkmann's ischemic contracture.

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Drug Interactions in Older Adults

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Introduction

Over 200 different drug interactions resulting in adverse effects in humans have been reported in the literature.[1] In most instances, coadministration of two medications with known interaction potential is still possible if appropriate adjustments are made. Therefore, clinicians must be prepared to make the proper therapeutic modifications in situations in which the patient is truly at risk. Older adults are at greater risk for drug interactions than their younger counterparts. The principal mechanisms by which drugs interact are the same regardless of the age of the patient, but older patients tend to present a therapeutically more complex picture.

Clinically significant adverse drug interactions can result in either increased drug toxicity or decreased therapeutic effects. The term "drug interaction" will be confined here to situations in which the effects of one medication are modified by the prior or concurrent use of another medication. Drug interactions with food or laboratory tests are not within the scope of this article. Rather than an exhaustive review of the drug interaction literature, this is an introduction to some of the basic principles involved. The reader is referred to other sources for more in-depth coverage of the topic.[2-5] It is impossible to remember all potential drug interactions; however, knowledge of the primary mechanisms through which drugs interact can enable a clinician to better predict, and thereby prevent, potential adverse effects.

Table 1. Clinical Characteristics of Drug Interactions

- Drug interactions exhibit high interpotient variability
- Drug interactions are difficult to detect
- Most drug interactions are dose-related
- The adverse effects of drug interactions are rarely immediate
- Individual drugs within a drug class may not interact with other drugs in a similar manner
- Drug interactions seldom represent a contraindication to continued use but may require adjustments in the dosage or timing of the dose

Table 2. Factors Leading to Potential Drug Interactions

- Increased medication consumption
- Changes in physiology
- Types of medications consumed
- Visiting more than one physician
- Noncompliance
- Presence of disease states
- Concurrent use of prescription and nonprescription medications

Clinical Characteristics of Drug Interactions

It is important to put potential drug interactions into perspective with respect to their clinical significance. Although the patient should be monitored for adverse effects, a clinician should not be overly alarmed each time it is necessary to prescribe a potentially interacting combination of medications. The clinical characteristics of drug interactions have been described by Hansten[6] and summarized by Lipton and Lee (Table 1).[7]

Factors Leading to Potential Drug Interactions

Several factors may place older adults at increased risk for experiencing drug interactions (Table 2).[8]

Increased Medication Consumption

As a group, older adults consume a disproportionate share of medications. The potential for an interaction when two medications are used in combination is 5.6%. This potential increases dramatically to 50% for five medications and 100% when eight medications are used concurrently.[9]

Changes in Physiology

Although it is often difficult to separate the effects of aging from the effects of disease, a person's response to medication changes over time. Age-related physiological changes (eg, decreased renal function) can contribute to a diminution of the ability to predict the magnitude of a medication's effect and interaction potential.

Types of Medications Consumed

Older adults are commonly prescribed medications that are frequently indicated in clinically significant drug interactions. These medications

include oral anticoagulants, cardiac drugs (eg, digoxin), anticonvulsants (eg, phenytoin), H_2 antagonists (eg, cimetidine), nonsteroidal anti-inflammatory drugs (NSAIDs), psychotherapeutic agents, and oral hypoglycemics.

Visiting More than One Physician

Many older individuals see more than one physician concurrently. It is common for patients to be going to one or more specialists in addition to their primary physician. In some cases the physicians do not know there are other prescribers for the patient, resulting in the potential for significant drug interactions with medications they are unaware of.

Noncompliance

Noncompliance with medication regimens is not unique to the elderly, but is of special concern among this age group. Noncompliance with prescribed medication regimens increases with the number of medications the patient must take, the complexity of the regimen, and the length of therapy.[10] Increases in each of these attributes are characteristic of the medication regimens of many older adults.

Presence of Disease States

Over 80% of persons 65 years of age and older have at least one chronic disease (eg, arthritis, hypertension), and among this group, as many as 40% suffer from two or more chronic conditions.[11] Disease-related physiologic changes increase the potential for drug interactions by causing changes in organ systems involved in drug disposition.

Concurrent Use of Prescription and Nonprescription Medications

Many patients do not consider the over-the-counter (OTC) products to be drugs. Many older adults use OTC medications without their physician's knowledge or direction. OTC products such as antacids, antihistamines, analgesics, and decongestants are commonly associated with potentially significant interactions with prescription medications.

Mechanisms of Drug Interactions

The mechanisms through which drug interactions are mediated are often categorized as being either pharmacokinetic or pharmacodynamic in nature (Table 3). Pharmacokinetic-mediated interactions involve an alteration of the absorption, distribution, metabolism, or excretion of a medication. Pharmacodynamic-mediated interactions may occur when two medications having opposing or similar actions are used concurrently or when one medication alters the sensitivity or responsiveness of the site of action to another medication.

Table 3. Mechanisms of Drug Interactions

I. Pharmacokinetic-mediated Interactions
- A. Absorption
- B. Distribution
- C. Metabolism
- D. Excretion

II. Pharmacodynamic-mediated Interactions

Pharmacokinetic-mediated Interactions

Absorption

Drug interactions that result from a change in absorption are most likely due to alteration of gastrointestinal (GI) pH, change in GI motility, or drug complexation and adsorption. An example of the latter involves coadministration of digoxin and medication (eg, antacids, kaolin-pectin, cholestyramine, colestipol) that binds with it, decreasing digoxin absorption. This interaction may be avoided by staggering dosage administration times.

Distribution

A medication may alter the distribution of another by changing its volume of distribution or by displacing it from plasma protein or tissue binding sites. The digoxin-quinidine interaction involves, in part, the displacement of digoxin from tissue binding sites, resulting in a significant increase in serum digoxin levels. Potential adverse effects may be avoided by a reduction in digoxin

dosage when quinidine therapy is instituted. Medications that are involved in plasma protein binding displacement interactions include oral anticoagulants, sulfonamides, phenytoin, digoxin, and NSAIDs. These types of interactions usually dissipate after several days, even if the medications continue to be taken concurrently.[1]

Metabolism

Alterations in drug metabolism usually involve an increase (enzyme induction) or decrease (enzyme inhibition) in the rate of metabolism by the liver. Alterations in the metabolism of one medication by another probably result in more clinically significant drug interactions than any other type of pharmacokinetic mechanism.[1] Examples of classic enzyme inducers of the hepatic mixed-function oxidase system include sulfonylureas, barbiturates, rifampin, carbamazepine, griseofulvin, meprobamate, and phenytoin. Enzyme inhibitors include chloramphenicol, cimetidine, influenza vaccine, isoniazid, allopurinol, disulfiram, metronidazole, erythromycin, and verapamil. For instance, a patient on chronic phenobarbital therapy would require larger doses of the anticoagulant warfarin to compensate for phenobarbital's inducing effect. On the other hand, a patient taking maintenance doses of cimetidine would require a lower than usual dose of theophylline to maintain therapeutic theophylline levels.

Table 4. Guidelines for Minimizing Occurrence of Drug Interactions

- Identify patient risk factors (eg, number of concurrent medications)
- Take a thorough medication history, including OTCs and home remedies
- Know the properties and pharmacology of the medications prescribed
- Avoid complex therapeutic regimens
- Use smaller doses
- Educate the patient regarding potential medication-related problems
- Monitor therapy and keep accurate records
- Individualize therapy
- Have up-to-date references available
- Keep the potential for drug interactions in perspective

Excretion

Mechanisms by which one medication alters the renal excretion of another consist of changing glomerular filtration rate (GFR), active tubular secretion, urine pH, or other renal parameters. Most excretion-related drug interactions involve a reduction in the renal elimination of one medication by another, resulting in increased plasma levels and possible toxicity.[1] The interaction between the antigout medication, probenecid, and penicillin illustrates a therapeutic coadministration to achieve a beneficial effect. Both drugs are excreted by active tubular secretion and concurrent use results in significantly higher and more prolonged penicillin plasma concentrations. Other medications that may be involved in excretion-related drug interactions include cephalosporins, methotrexate, NSAIDs, sulfinpyrazone, and thiazides.

Pharmacodynamic-mediated Interactions

Pharmacodynamic-mediated interactions involve the cumulative effects of two or more drugs with similar or opposing pharmacologic action. Perhaps the most common of all cumulative drug interactions is due to the CNS-depressant effects of several drugs (eg, alcohol, antidepressants, anxiolytics, sedative-hypnotics). Another example of an interaction involving drugs with similar pharmacologic properties consists of digoxin, beta blockers, and verapamil. Coadministration of these medications can produce additive atrioventricular blockade. Various examples also exist for competitive antagonism at receptor sites for certain drug combinations. For instance, the $beta_2$ agonist, terbutaline, and the beta blocker, propranolol, exert opposing pharmacologic action at $beta_2$ receptor sites.

Conclusions

The list of drug interactions in the elderly is too long to commit to memory. Consequently, a general understanding of mechanisms involved in drug interactions should assist the prescriber in anticipating and preventing adverse effects. Furthermore, any new signs or symptoms following addition of a new drug to an existing medi-

cation regimen may signal a possible drug interaction. When prescribing medications, the guidelines outlined in Table 4 should be followed in an effort to minimize the potential occurrence of drug interactions.[12]

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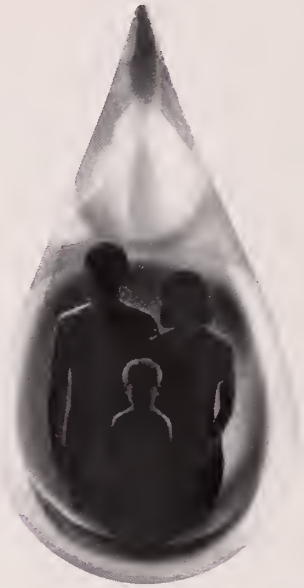

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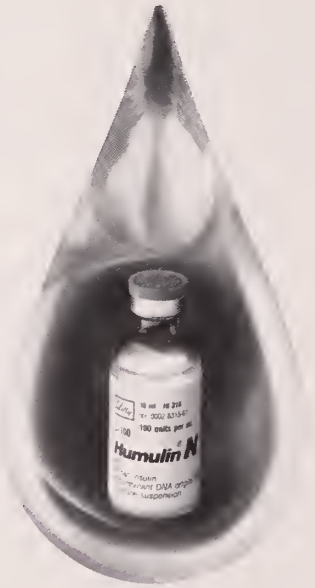

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The Managing Editor

Redesigning the *Journal* has been a long and difficult process but is now beginning to mature into an attractive, enticing improvement. My notion to undertake a design change was accepted without wild enthusiasm by the Board of Editors but the members were kind enough to allow me to proceed. We shopped for graphic designers to help execute the change, then applied to the KMA Board of Trustees for money to effect it. The Board of Trustees was somewhat reticent but was tolerant enough to grant us a significant amount of money.

The new design was developed and proposed, agonized over, reworded, more agony, then printed. The result was not as outstanding or as enduring as we had hoped. After a while our Managing Editor, Sue Tharp, began a slow redesign of the redesign making thoughtful, considered changes over a long period of months. This process continues.

Dr Paul Fisher, Professor of Journalism at the University of Missouri School of Journalism, has, as a function of the State Medical Journal Advertising Bureau, conducted critiques of journal members of the SMJAB for many years. His judgements on recent journal issues include:

> "Kentucky Medical clearly has been substantially redesigned; it has been styled, and this depends on some relatively simple specifications consistently followed.
>
> "It shows a very pleasant page layout. The large vertical drop on the side allows a great deal of light into the page.
>
> "It has established an editorial profile making it a predictable and very usable publication."

Sue Tharp is quietly competent, imaginative, talented and thorough in every aspect of her management of the *Journal* production. Her name is printed at the bottom, but her job is tops.

A. Evan Overstreet, MD
Editor

Your Direct Line to practical office solutions.

If you're running out of patience with your old space, maybe it's time *you* called a specialist. Whether your needs are site location, blueprint consultation, ground-up renovation, space planning or final touches on your interior decor, Burdorf-Kessler has the skills and knowledge you need to create your space with style.

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Come to Owensboro — April 23-25!

'All auxilians are encouraged to attend. If you are not yet a member of the medical auxiliary, this is a great time to become involved. As an auxilian you are part of more than 1,000 physicians' spouses in our state who share the mutual goal of enhancing the quality of life of all Kentuckians.'

Daviess County beckons all Kentucky physicians' spouses to make plans now to attend AKMA's Annual Convention and House of Delegates Meeting, to be held in Owensboro from April 23 to April 25! The meeting will be held at the beautiful and hospitable Executive Inn Rivermont and will be hosted by the Daviess County Auxiliary under the very capable and enthusiastic leadership of Pam Blackstone and Marna Loucks. We are excited about having you in Owensboro, and Pam and Marna have planned a variety of activities to help make your stay memorable. There will be fun, fellowship, and most importantly, you will hear the "progress report" of your auxiliary.

ALL auxilians are encouraged to attend. If you are not yet a member of the medical auxiliary, this is a great time to become involved. As an auxilian you are part of more than 1,000 physicians' spouses in our state who share the mutual goal of enhancing the quality of life of all Kentuckians. During this past year, through community and statewide projects, auxiliary efforts have targeted a wealth of concerns such as teenage pregnancy, AIDS education, infant safety, cholesterol testing, organ donation, drunk driving, physical fitness, and blood bank programs. And, you have supported Kentucky's Ronald McDonald Houses, raised scholarship money for students embarking on health careers, and have contributed record amounts to the American Medical Association-Education Research Foundation (AMA-ERF). You will hear reports on these activities as well as auxiliary involvement in legislative awareness and in other areas during this past year.

April is the time of our area's dogwood and azalea splendor, and if our winter freezes allow for a glorious display again this year, we will arrange to share this beauty with you while you are here. We are hoping, too, that the Ohio River will cooperate enough for a ride aboard the Executive Queen on Monday afternoon. Shopping guides will be provided for your free moments and the Daviess County Players will surely be on call for your entertainment. Come in early on Sunday evening and join us between 6 PM and 10 PM for a complimentary light supper in the hospitality suite. And if your physician spouse wishes to join you on this visit to Owensboro, they will find several golf courses available for their enjoyment. The meeting will conclude on Wednesday, April 25, by 12 Noon.

Watch for a complete schedule and registration information in the BLUEGRASS NEWS, or write for details to: Jean Wayne, AKMA Executive Secretary, 3532 Ephraim McDowell Drive, Louisville, KY 40205 (502-459-9790).

See you in Owensboro!

Esther Jansing
AKMA President

'We are excited about having you in Owensboro. . . . There will be fun, fellowship, and most importantly, you will hear the "progress report" of your auxiliary.'

KMA Supports "TV Worth Watching" on KET

KMA members across the state are urged to tune in — and call in — to KET March 3-18 during TeleFund '90. Members across the state will be especially interested in calling Wednesday evening March 14. Phone bank volunteers for that evening will be members of the Fayette County Medical Association representing the state organization.

This year marks the seventh year of partnership between the KMA and KET. KMA members from across the Commonwealth pool resources to form a group contribution to the Fund for Excellence, KET's program of major giving. During 1989, individual KMA members contributed more than $50,000 in support of the outstanding evening and weekend programs on KET.

Be sure to tune in for the great programs during TeleFund — and call in your support for "TV Worth Watching" on KET!

Volunteers from the Fayette County Medical Society representing the Kentucky Medical Association work the phone banks during KET's Tele-Fund '89. First Lady of Kentucky Martha Wilkinson cohosted the evening.

After the accident, I wasn't the same person.

Having a head injury is like losing a part of yourself. I know. I was in a near-fatal car crash and sustained a serious blow to the head. When I awoke from a coma, I was not the same person. Physically I was disabled. But there were other—less apparent—changes.

I was a straight "A" student before the accident. But the head injury caused long-term problems involving memory loss, concentration and following directions.

Luckily I found Frazier Rehab Center. They helped rebuild my physical strength and gave the support I needed to learn to cope.

And now Frazier is offering a new outpatient service called the Community Re-Entry Program. It's specifically designed to help people with head injuries develop the skills and self-confidence to return to work or school.

I'm living proof that it is possible to return to the mainstream of life. It's not easy, but I welcome the challenge of learning something new—even about myself.

In fact, I've discovered I like who I am a little bit more every day.

If you would like more information about our head injury services, call Frazier Rehab Center at 1-800-866-4415 or 587-4173.

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220 Abraham Flexner Way • Louisville, Kentucky 40202

Four New Officers Elected to KMA Board of Trustees

During the 1989 KMA annual House of Delegates meeting held in Louisville, four new officers were elected to serve on the Board of Trustees. KMA congratulates the following members on their election and thanks them for their valuable leadership.

C. Kenneth Peters, MD, a Jeffersontown family practitioner since 1963, was elected Vice-Speaker of the House of Delegates. Dr Peters has given many years of dedicated service to his profession, and KMA's 181 delegates present at the Annual Meeting, representing approximately 5,500 members, acknowledged this by electing him to this three-year term.

Dr Peters, 55, brings to this office extensive experience in organized medicine. He is currently president of the Jefferson County Medical Society, has served as KEMPAC chairman, on the KMA Legislative Committee 13 years, co-chairman of the Jefferson County Legislative Committee 15 years, KMA Delegate 20 years, and has been a member of KMA since his first year of practice in 1963. He is a Charter Fellow of the American Academy of Family Practitioners and a member of the Jefferson County Academy of Family Practitioners.

A 1957 graduate of Kentucky Wesleyan College, Dr Peters received his medical degree from the University of Louisville School of Medicine in 1960. After serving an internship at St Joseph Infirmary in 1960-61, he served as a US Navy Medical officer in 1961-63.

Doctor Peters has privileges at Suburban, Methodist, and Baptist Hospitals.

A native of Owensboro, Dr Peters and his wife Rhoda, Director of Programming for St Paul United Methodist church, reside in Louisville. They have three children.

Larry C. Franks, MD, was elected to serve a two-year term as an Alternate Delegate to the AMA.

A specialist in obstetrics and gynecology, Dr Franks practices in Paducah. A native of Sullivan, Indiana, he was graduated with distinction from Indiana University in 1963 and received his medical degree in 1967 from Indiana University School of Medicine. Dr Franks served his internship at Methodist Hospital of Indiana, Indianapolis, during the period 1967-1968, and his residency at the same hospital from July 1968 through November 1968, and November 1970 through June 1973. He served on active duty as a Captain in the Medical Corps of the US Air Force from 1968 through 1970.

Having joined KMA in 1974, Dr Franks is not new to the realm of organized medicine. His contributions include service as a KMA Delegate for three terms and as a current member of the KEMPAC Board. He is a Fellow of the American College of Obstetrics and Gynecology, a Diplomate of the American Board of Obstetrics and Gynecology, a past president and past secretary-treasurer of the McCracken County Medical Society, and a member of the American Fertility Society and the Southern Medical Association.

Dr Franks has privileges at Lourdes Hospital in Paducah where he has served as secretary of the medical staff and chief of surgery, and currently serves on the Executive Committee. He is also affiliated with Western Baptist Hospital in Paducah where he has served as chairman of the Medical Records Committee.

Dr Franks and his wife, Carol, a past president of the AKMA, have three children and reside in Paducah.

Robert P. Meriwether, MD, a Paducah neurosurgeon, has been elected 1st District Trustee for a three-year term.

A member of KMA since 1982, Dr Meriwether also serves on the KMA Physician-Attorney Liaison Committee. Other professional memberships include the Congress of Neurological Surgeons, Board of Examiners-American College of Surgeons, Southern Neurosurgical Society, a Diplomate of the American Association of Neurological Surgeons and a Fellow of the American College of Surgeons.

Dr Meriwether, who has published several articles and presented medical papers before prestigious groups in the US and abroad, earned his BS from the University of Kentucky in 1969 and his medical degree from Tulane University Medical Center, New Orleans, in 1973. He interned at Charity Hospital, New Orleans, in 1973-74, and accomplished his residency at Charity Hospital and Veterans Administration Hospital in New Orleans, from 1974-76.

Hospital affiliations are Lourdes and Western Baptist in Paducah, where he has served as Chief of Staff and Chief of Surgery respectively; Murray-Calloway County in Murray; Community in Mayfield; Harrisburg Medical Center, Harrisburg, Illinois; and the University of Kentucky, where Dr Meriwether serves as an Assistant Professor of Neurological Surgery.

Dr Meriwether, 42, and his wife, Gloria, have three daughters and live in Paducah.

William L. Miller, MD, a pathologist in Greenville, was elected to serve a three-year term as 3rd District Trustee.

Dr Miller brings several years of experience to his KMA office. In his first year of membership, 1977, he served as an Alternate Delegate for Muhlenberg County and has continued to serve several terms as both an Alternate Delegate and Delegate to KMA. He is the current Specialty Group and Geographic Representative for Pathologists on the Ad Hoc Committee on Professional Liability Insurance. Professional memberships include the College of American Pathologists, American Society of Hematology, International Academy of Pathologists, Kentucky Society of Pathologists, and a Fellow of the American Society of Clinical Pathologists.

A native of Louisville, Dr Miller, 55, earned his BS degree from the University of Louisville in 1955 and graduated cum laude from the U of L School of Medicine in 1959. He interned in 1959-60 at Boston City Hospital and Mallory Institute of Pathology, Boston, Massachusetts, and completed a residency in anatomic pathology at Massachusetts General Hospital, Boston, in 1960-61, and Clinical Pathology at Louisville General Hospital in 1961-63.

Dr Miller is Chief Pathologist at Muhlenberg Community Hospital and an Associate Clinical Professor at the U of L School of Medicine. He has published several articles and lectured extensively in the US and abroad.

He and his wife, Fae, have four children and reside in Morgantown.

PEOPLE

William T. Applegate, Executive Director of KMA, was elected President-Elect of The Professional Convention Management Association (PCMA) during its 34th annual meeting held recently in New Orleans.

PCMA is an organization of individuals who have responsibility and/or accountability for the management of meetings, conventions, exhibitions and/or educational, scientific or technical programming for professional organizations in the fields of health and health care, science, education and engineering. Its members generate some $6 billion in meeting revenue each year.

KMA Executive Vice President, Robert G. Cox, noted that successful involvement in organizations like PCMA resulted in KMA continuing to have one of the outstanding annual meetings of all state medical associations and an exhibit hall that routinely has a waiting list.

A graduate of the University of Louisville, Mr Applegate has been with KMA for the past 18 years and has been a PCMA member since 1972. He has served on various committees and on the board of directors. He will be installed as President of PCMA in January 1991 for a one-year term in office.

Freddie L. Terrell, University of Kentucky College of Medicine student, recently was awarded first place for his medical research conducted at the University. Mr Terrell, son of Ray and Loretta Terrell, Buskirk, KY, received the honor at the annual College of Medicine Student Research Day.

Chosen by UK College of Medicine faculty, he will present his research project entitled "Relationships Between Serum Lactate and Blood Volume Removed During Continuous Hemorrhage," at the National Student Research Forum in Galveston, Texas in April. He will compete against medical students from across the nation.

Mr Terrell, a second-year medical school student, is a member of the Ward O. Griffen Surgery Club. He is an undergraduate of Georgetown College and a 1984 graduate of Morgan County High School.

UPDATES

Zeroing in on Cancerous Targets

The University of Louisville reports that a radiation probe no larger than a pencil is helping doctors locate and destroy cancerous tumors with less threat to healthy cells.

The Remote High Dose Afterloader is used primarily to treat esophageal, lung, and gynecologic cancers. When inserted into the body near the cancer, the probe directs radiation to an area within one millimeter of its target.

The probe reduces treatment time, spares normal cell tissue, and lowers radiation exposure to medical personnel, according to the University.

Family Doctor Group Urges Second Measles Vaccination

A report from The American Academy of Family Physicians (AAFP) recommends routine second measles, mumps and rubella (MMR) immunizations for children 4 to 6 years of age, or just prior to entering school. The national association representing more than 68,000 family doctors, residents, and medical students also said that children in areas where there is a high risk of contracting measles should receive their first MMR at 12 months, instead of 15 months of age.

The AAFP's revised guidelines calling for two childhood measles vaccinations concur with the Immunizations Practice Advisory Committee's report: "Measles Prevention," issued recently by the federal Centers for Disease Control (CDC). The AAFP has a liaison representative to the CDC committee.

The AAFP revised its schedule for MMR vaccinations because of the increasing number of infants, children, and adolescents who have contracted measles. Some of these cases occurred in children who were previously immunized, but failed to develop protection against measles.

Although the AAFP's and CDC's recommendations generally call for a first measles shot at 15 months and a second shot at 4 to 6 years of age, some states may require the second MMR to be given at an older age. In addition, authorities in high risk areas might advise the first MMR to be given at 12 months of age. The new guidelines define a high risk area as a county or portion of a county with:

— more than five measles cases among preschool-aged children during each of the last five years;

— a recent outbreak among unvaccinated preschool-aged children; or
— a large urban population

"The CDC recommends a second MMR shot or a measles immunity test for everyone who is going to college or other educational institutions beyond college, as well as medical personnel beginning employment who will have direct patient care contact," said Gerald C. Keller, MD, who chairs the AAFP's Commission on Public Health and Scientific Affairs.

Persons who are *not recommended* to receive a measles vaccination generally include pregnant women, persons with active tuberculosis, or who have allergies to eggs, Dr Keller said.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Boyd

Khan Matin, MD — P
2203 Lexington Ave, Ashland 41101
1970, Dacca Medical College

Campbell

John H. Lacy, MD — SU
40 N Grand. #202, Ft Thomas 41074
1983, University of Louisville

Christian

John A. McCubbin, MD — OPH
2116 S Main, Hopkinsville 42240
1979, University of Louisville

Daviess

Antonio P. Sison, MD — R
PO Box 570, Owensboro 42301
1983, University of Kentucky

Fayette

Paul D. DePriest, MD — OBG
3965 Spurr Rd, Lexington 40511
1985, University of Kentucky

Joseph E. Gerhardstein, MD — FP
149 Forest Ave, Lexington 40508
1984, University of Kentucky

Robert V. Higgins, MD — OBG
3297 Shoal Lake Dr, Lexington 40515
1982, East Carolina U School of Medicine

Terence C. Ross, MD — C
1401 Harrodsburg, A300, Lexington 40504
1981, Jefferson Medical College

H. David Wilson, MD — PD
3133 Lamar Dr, Lexington 40502
1966, St Louis University of Medicine

Franklin

Lawrence J. Sprecher, MD — IM
1 Physicians Park, Frankfort 40601
1986, Indiana U School of Medicine

Jan J. Weisberg, MD — OTO
5 Physicians Park, Frankfort 40601
1967, University of Wisconsin

Fulton

Alejandro V. Albano, MD — IM
Parkway Doctors Pavilion, Fulton 42041
1981, University of Santo Tomas

Jefferson

David B. Britt, MD — IM
5625 Morrison Ave, Louisville 40214
1986, University of Louisville

Ann C. Huntington, MD — OPH
5129 Dixie Hwy, Louisville 40216
1976, University of Manchester

Ellen Porter Knox, MD — P
1400 Willow, #1604, Louisville 40204
1983, University of Louisville

Gary S. Marshall, MD — PD
3412 Broeck Pointe Cir, Louisville 40241
1983, Vanderbilt University

Mark E. Petrik, MD — ORS
364 Medical Towers S, Louisville 40202
1983, Vanderbilt University

Lynn T. Simon, MD — N
1112 Dupont Cir, Louisville 40207
1985, University of Louisville

Jessamine

Stephen P. Royse, MD — FP
106 Peachtree, Nicholasville 40356
1976, University of Kentucky

Kenton

Gregory L. Salzman, MD — GE
372 Longmeadow Ln, Ft Mitchell 41017
1984, Ohio State

Richard B. Williams, MD — SU
242 Applewood Dr, Lakeside Park 41017
1981, University of Kentucky

Madison

Nancy R. Ryan, MD — FP
Berea College, CPO2318, Berea 40404
1981, Medical College of Pennsylvania

McCracken

Dale P. Figge, MD — OBG
216 Berger Rd, Paducah 42003
1967, Indiana University

Bradley B. McElroy, MD — CC
PO Box 7648, Paducah 42001
1984, University of Missouri

Marshall

James E. Holmes, DO — GP
PO Box 367, Benton 42025
1975, Col Phy/Sur, Kansas City

Oldham

Ernesto M. Camacho, MD — FP
PO Box 463, LaGrange 40031
1953, Manila Central University

Pike

Mary Lyn T. Lu, MD — EM
534 S Mayo Tr, #211, Pikeville 41501
1978, University of the East

New In-Training

UK
John Randall Thompson, MD — IM

Cincinnati
Michael Cholera, DO — FP

DEATHS

Frank H. Moore, MD
Bowling Green
1916-1989

Frank H. Moore, MD, an internist, died December 23, 1989. A 1941 graduate of Tulane University of Louisiana School of Medicine, Dr Moore was a life member of KMA.

William K. Keller, MD
Louisville
1906-1990

William K. Keller, MD, a psychiatrist, died January 29, 1990. A 1931 graduate of the U of L School of Medicine, he was chairman of the department of psychiatry at U of L from 1964 until he retired in 1973. The Keller Child Psychiatry Research Center at U of L was named in his honor. Dr Keller was nationally known as a leader in promoting highway safety and was an early advocate of a state law requiring seat belts in cars. He was a former chairman of the AMA's Committee on Automotive Safety, charter member of the President's National Motor Vehicle Safety Advisory Council, and former president of the American Association for Automotive Medicine. Dr Keller was president of the Kentucky Psychiatric Association from 1942 to 1946 and vice president of the Jefferson County Medical Society in 1946. He was a life member of KMA.

Elmer E. Devillez, MD
Covington
1906-1990

Elmer E. Devillez, MD, a pediatrician, died January 29, 1990. Dr Devillez was a 1930 graduate of the University of Louisville School of Medicine. He became an active member of KMA in 1932 and a life member in 1975.

RURAL KENTUCKY MEDICAL SCHOLARSHIP FUND APPLICATIONS

The Rural Kentucky Medical Scholarship Fund is accepting applications from residents of Kentucky, who have been accepted at the University of Kentucky College of Medicine or the University of Louisville Medical School. The Fund offers a $10,000 loan per year of medical school to a qualified recipient who is willing to practice and reside in a rural county in Kentucky for one year for each loan received. The interest rate will be one-half of the prime rate on May 1. Special forgiveness of loans is available to those who practice in one of Kentucky's critical counties. The Fund is the oldest and most successful of its kind in the nation. The Rural Kentucky Medical Scholarship Fund has loaned approximately $3 million to over 500 medical students.

The deadline date for filing an application is **April 15.** Anyone interested in applying for a scholarship loan should contact the RKMSF Office at the Kentucky Medical Association Headquarters, 3532 Ephraim McDowell Dr, Louisville, KY 40205, or call 502-459-9790.

What is your specialty?

Doctor of Medicine (MD)
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Kentucky Air National Guard
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"Excellent Speakers!"

"Great subject matter for young MD's!"

"Great opportunity to participate in KMA/YPS & have a weekend off!"

Physicians are still talking about the 1st annual Young Physicians Seminar. Make plans now to attend:

KMA's 2nd Young Physicians Seminar

April 27 & 28, 1990
French Quarter Suites Hotel
2601 Richmond Road
Lexington, KY

Program to include: discussion on contracting; the business side of medical practice; the role of practice administrators in the small practice; national and state legislative activities; and RBRVS - the future of medicine.

Watch for brochure mailing and future issues of the "Communicator" or call the KMA Headquarters Office - (502) 459-9790 - for further details.

A NEW DECADE

• 1 9 9 0 •

Pride in Medicine

KMA ANNUAL MEETING • SEPTEMBER 24-27 • HYATT REGENCY-COMMONWEALTH CONVENTION CENTER • LOUISVILLE, KENTUCKY

This year's KMA Annual Meeting will be held in downtown Louisville at the Hyatt Regency Hotel and Louisville Convention Center. KMA is looking forward to hosting the meeting on September 24-27, at a location that offers ample meeting and exhibit space along with a variety of sightseeing, shopping and dining facilities. Louisville is an ideal convention city and ranks among the country's top ten cities in convention attendance. At the same time it ranks the lowest in food and lodging costs.

Convention Center and Hotel

The Commonwealth Convention Center, 221 Fourth Avenue, which will be the location for the scientific sessions and exhibit hall during the Annual Meeting is one of the most functionally designed facilities of its kind. All meeting facilities are attractively decorated and carpeted and have versatile lighting, computer climate control and a sophisticated sound system.

The Hyatt Regency Hotel located at 320 W. Jefferson Street, is a 17-story atrium hotel overlooking the Ohio River in the heart of Louisville's business and entertainment district. The hotel features three restaurants; Stetson's Bar and Grill; Trellis Cafe with a full service menu located on the first level; and the Spire, an elegant, revolving roof top restaurant that offers a breathtaking view of Louisville's skyline. Live entertainment is also offered most evenings in the Balcony Lounge. As a break between meetings, the hotel offers swimming in the indoor pool, relaxing in the hydrospa or taking advantage of the tennis court. The hotel is conveniently connected by a covered skywalk to the Commonwealth Convention Center, the location for the scientific sessions and exhibit hall. The skywalk also connects the hotel to exceptionally fine shopping at the Galleria Mall with its 7-story glass-enclosed atrium and over 80 retail shops including major department stores and restaurants. The hotel and Commonwealth Convention Center, in renovated downtown Louisville, are both ideally located to take advantage of sightseeing, shopping, and dining.

It is important that you begin to make your room reservations as soon as possible for the meeting September 24-27. The Hyatt Regency Hotel will be the headquarters hotel, (502) 587-3434. In making reservations, **please be sure** that you indicate you are attending the Kentucky Medical Association Annual Meeting to receive a **special convention rate:** single $65 and double $75.

kma

AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

Marital Status: _____

Spouse's Name: _____

Children: _____

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 3532 Ephraim McDowell Dr, Louisville, KY 40205

Deadline for receiving nominations is July 15.

Twelfth
Family Medicine Review
University of Louisville

June 23-29, 1990

ACLS — June 23-24, 1990
Review — June 25-29, 1990

ACLS — $125.00 Review — $370.00
ACLS & Review — $440.00

CONTACT: Gerald D. Swim, Director
Continuing Medical Education
School of Medicine
University of Louisville
Louisville, Kentucky 40292
(502) 588-5329

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MARCH

21-22 — Fifth Annual Geriatric Seminar — "Practical Problems Facing the Practicing Physician." Jewish Hospital, Bottigheimer Auditorium, Louisville, KY; $85 for physicians, $55 for non-physicians. Contact: Terri Graham, RN, Director of Family Practice/Senior Services, Jewish Hospital, 217 E. Chestnut St., Louisville, KY 40202-1886, (502) 587-4685.

23-24 — Kentucky Thoracic Society 35th Annual Scientific Conference on Pulmonary Disease. Hilton Suites of Lexington Green, Lexington, KY. Contact: American Lung Association of Kentucky, P.O. Box 969, Louisville, KY 40201; (502) 363-2652.

30 — "Pancreatitis in the 1990s: Diagnostic and Therapeutic Advances," sponsored by the Department of Surgery at the University of Cincinnati Medical Center. This course has been submitted for 7 CME credit hours. Cost: $75.00. Contact: Aaron S. Fink, M.D.

30-31 — Contemporary Pediatrics for the Practicing Physician. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

30-April 1 — Pediatrics 1990. Marco Island Hilton Hotel, Marco Island, FL. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

APRIL

5-6 — 17th Annual Symposium on Obstetrics & Gynecology. Washington University Medical Center, St. Louis, MO. AMA Category 1 approved. Contact: Cathy Caruso, Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

6-7 — Aggressive Management of Diabetes and Obesity. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

6-7 — Clinical Advances in Treatment of Retina, Vitreous, and Uveal Diseases for the Practicing Ophthalmologist. Marriott's Griffin Gate Resort, Lexington, KY. Contact: Karen Heidorn, Humana Hospital-Lexington, 150 North Eagle Creek Drive, Lexington, KY 40509, (606) 268-3754.

19-21 — The Virginia Society of Otolaryngology — HNS, Radisson Mark Plaza Hotel, Alexandria, VA. Guest speakers: Roy B. Sessions, M.D.; Charles Gross, M.D. Contact: Donna Scott, 4205 Dover Road, Richmond, VA 23221; (804) 353-2721.

21 — Annual Oropharyngeal Cancer Symposium, "The Management of Post Treatment Problems in Head and Neck Cancer Patients," Health Sciences Center Auditorium, Louisville, KY. Co-sponsored by the American Cancer Society, Kentucky Division, the Kentucky Cancer Program, and the James Graham Brown Cancer Center. Contact: Pat Warring (502) 588-7870.

27-28 — Sports Medicine for Physicians. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

MAY

9-12 — 39th Annual Scientific Assembly, Kentucky Academy of Family Physicians, Galt House, Louisville, KY. Contact: KAFP, 3323 Medical Arts Bldg, Louisville, KY 40217, (502) 451-0370.

11-12 — Low Back and Sciatic Pain: Evaluation and Treatment; Washington University Medical Center, St. Louis, Mo. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

16-19 — 13th Annual National Conference, "Rural Health! Empowered to Make a Difference," sponsored by The National Rural Health Association. Sheraton New Orleans Hotel, New Orleans, LA. Former U.S. Surgeon General C. Everett Kopp, MD will present the conference's keynote address. Contact: Robert Quick, Communications Director, National Rural Health Association, 301 East Armour Blvd., Suite 420, Kansas City, MO 64111; (816) 756-3140.

19 — Trauma Symposium. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

20-26 — Twenty-First Family Medicine Review — Session II. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

25-27 — Advances in Pediatrics. Marriott's Hilton Head Resort, Hilton Head Island, SC. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd., PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

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1-2 — 3rd Annual Contact Lens Course. Washington University Medical Center, St. Louis, MO. AMA Category 1 approved. Contact: Cathy Caruso, Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

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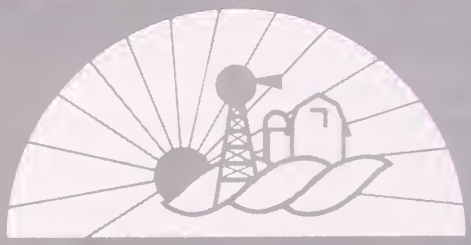

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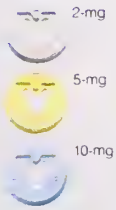

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At the AMA National Leadership Conference 1990, held in February in Phoenix, Arizona, the AMA unveiled a comprehensive program for strengthening the US health care system. In the face of rising costs of care, lack of access to care by millions of Americans, and mounting public and governmental pressure, the AMA has formulated a plan to address these issues *within our current system.* "Health Access America" was previewed for physicians and staff at this conference and reviewed in detail at a two-day National Communications Conference which followed. It is a formidable, 16-point proposal that is expected to dominate the Association's activities for several years. Even with innovative thinking and unity of action it will take years to achieve the goal of giving the "medically vulnerable" — the uninsured, underinsured, and the uninsurable — ready access to what other Americans already enjoy — the world's most advanced medical health system.[1] The foremost objective of this campaign is to stimulate enactment of legislative and other programs to assure affordable coverage of quality health care services for the 33 million Americans who now lack either public or private health insurance.

***'In the face of rising costs of care, lack of access to care by millions of Americans, and mounting public and governmental pressure, the AMA has formulated a plan to address these issues* within our current system.'**

As the first step in a nationwide information and education campaign, the program was made public at a Washington, DC press conference on March 7. Dr Alan R. Nelson, AMA President, and Dr James S. Todd, AMA's Acting Executive Vice-President, were the Association's spokespersons. Subsequently, the proposed plan and its objectives are being discussed by members of AMA's Board of Trustees at media tours in 24 major cities across the country. Kits were mailed to all national medical specialty societies and state medical associations. Kits will be made available to county medical societies. These leadership kits provide information to help each of us to answer the questions we are asked about the proposals following the "media blitz." I will not attempt to list all 16 objectives of the program, but the main guidelines are:

- Improvements to the American health care system should preserve the strengths of our current system.
- Affordable coverage for appropriate health care should be available to all Americans, regardless of income.
- Particular efforts are needed to assure continued access by the elderly to affordable health care services.
- Health care services should be delivered with high quality at appropriate costs.

'I am pleased to tell you that Kentucky has already recognized and begun to address some of these issues. . . .'

- Patients should be free to determine from whom and the manner in which health care benefits are delivered.
- All physicians should be committed to the highest ethical standards in the delivery of care to patients.

This plan envisions expanding access to health care coverage to all

Americans while undertaking actions to control inappropriate costs, reduce paperwork and bureaucracy, and to improve the professional liability climate. The complete list expands this outline and is formulated of 16 positive, pro-active proposals. If you have not seen this information and would like a copy, call or write KMA Headquarters, Louisville.

We should study it and be able to explain it in our own membership and the public — and to begin implementing it. It, of course, cannot be done overnight. "Health Access America" calls for dramatic change — substantial reform of the Medicare and Medicaid systems and for *required* employer-provided insurance. There is certain to be opposition to the proposal to create uniform eligibility standards for Medicaid patients based *solely* on income below the poverty level and to create a fiscally sound Medicare program. Both private and public insurance would be required to provide a designated level of benefits.[2]

'We must convince them that we can build upon the strengths of the US health care system, address its weaknesses, and provide access to quality care at reasonable cost.'

'Even with innovative thinking and unity of action it will take years to achieve the goal of giving the "medically vulnerable" — the uninsured, underinsured, and the uninsurable — ready access to what other Americans already enjoy — the world's most advanced medical health system.'

I am pleased to tell you that Kentucky has already recognized and begun to address some of these issues with our legislative programs to enact reform in the professional liability system, to provide health care for the indigent, and to make health education mandatory in grades K-12 in all Kentucky schools.

What is this all about and why now? Time is running out for us in the practice of medicine as private enterprise unless *we* can implement the necessary changes.

The bipartisan Congressional Pepper Commission, mandated almost two years ago to study the American health care delivery system, recently made its report and recommendations for solving the problems of the uninsured and for long-term care for the elderly and disabled. Headed by Senator Jay Rockefeller (R-WVa), the Commission was congratulated for identifying the problems, but could not develop a plan for funding for the $66 billion program. The search for support and funding continues. AMA Past President Dr James E. Davis was one of the 15 members of the Commission. The AMA recognizes the validity of the Commission's findings but wants any changes made to be done *within* the current health care system. A more radical approach was taken by Representative Mary Rose Oakar (D-Ohio), who introduced a bill in the Congress calling for government-sponsored national health insurance. It is obvious, then, that organized medicine must act now to inform our patients and their families, our communities, our legislators, business, labor, and the general public. We must convince them that we *can* build upon the strengths of the US health care system, address its weaknesses, and provide access to quality care at reasonable cost. "Health Access America" is the most comprehensive, positive program yet developed. Consider the proposals and find a place where *you* can be pro-active. Our future depends on it.

Nelson B. Rue, MD
President

References

1. AMA FEDNET "Priority Message #90-06"; 1 Mar, 1990.
2. AMA; "Health Access America — A Communications Workbook"; Feb 1990; p 7.

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1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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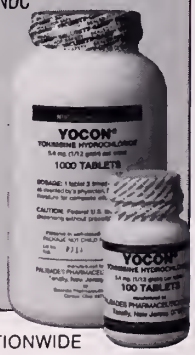

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A report by AMA Delegate Wally O. Montgomery, MD, FACS

In order to assure continuity, each member of the Kentucky Medical Association's Delegation to the AMA is assigned a specific reference committee. Traditionally, all reports related to hospital medical staff problems and concerns are referred to Reference Committee D of the AMA House of Delegates. The Hospital Medical Staff Section of the AMA meets immediately before the Annual and Interim Meetings of the AMA, and many members of that section are present at the reference committee. Also, many late Resolutions from the Hospital Medical Staff Section are presented at that Reference Committee from the Speaker of the House of Delegates.

Members of the American Hospital Association are always in attendance at the Reference Committee meeting, and are usually represented by the President. As might be suspected, many of the delegates and alternate delegates to the AMA are medical directors of their hospital staffs and, because of this, they are frequently in attendance at meetings of Reference Committee D. The Joint Commission on the Accreditation of Health Organizations is always represented at the meeting, usually by Dr Dennis O'Leary, who is the President. There are 18 commissioners to the JCAHO and 9 of these commissioners are appointed by the AMA. Always, the senior commissioner to the JCAHO, and usually 2 or 3 of the commissioners, are members of the Board of Trustees of the AMA.

At the 1989 Interim Meeting of the AMA House of Delegates, very few items were brought before Reference Committee D, but those presented were of real significance. A prime concern was that of small hospitals, which are required to have risk review committees, quality assurance committees, and a multitude of other committees to adhere to the standards of the Joint Commission as well as state and federal regulatory bodies. There has been much concern about trying to consolidate these various requirements into a more streamlined system, so that the hospital medical staffs do not have to spend so many hours adhering to standards. The cost of these committee functions in both time and money has prompted many hospitals to consider discontinuing Joint Commission approval, realizing that they would also lose many other benefits of such accreditation.This would have a significant adverse effect on the medical staff as well as the patients served by those smaller hospitals.

Traditionally, all reports related to hospital medical staff problems and concerns are referred to Reference Committee D of the AMA House of Delegates. . . . With the advent of health insurance companies requiring precertification and demanding limited hospital stays, the work of Reference Committee D . . . is becoming more important.

Another consideration at the Interim Meeting involved hospital dumping, or more aptly termed, inappropriate transfers. The concern here is that hospitals should not refuse to accept patient transfers on the basis of economics, and there should be an appropriate patient transfer agreement worked out between hospitals, so the patient may receive the optimal amount of care, unrelated to the insurance coverage that patient may have. A Resolution adopted by the Reference Committee and subsequently by the House of Delegates stated that a physician serving in various medical staff leadership positions, absent malice, should be fully indemnified and held harmless by the hospital.

Fiscal concerns and viability of hospitals are a major factor in the practice of medicine today. . . .

Other items of importance to hospital medical staffs were considered. The House voted that all hospital medical staffs should have in their bylaws a mechanism to address im-

paired physicians and deal with these individuals. It was also voted that department chairmen of medical staffs should be selected by the staff of the hospital and not by the hospital administrative board. There was a consensus that the hospital medical director should be a physician approved by the medical staff of the hospital. It has been a long-standing opinion of the AMA House that the medical staff has the right to nominate, elect, and seat its own officers. The administrative board of the hospital has no authority to reject those officers seated by the medical staff.

The cost of these committee functions in both time and money has prompted many hospitals to consider discontinuing Joint Commission approval, realizing that they would also lose many other benefits of such accreditation.

Another concern is the problem of physicians who have contracts with alternate delivery systems but who may not be on the medical staff of the hospitals that contract with the alternate delivery system. The patient and the physician both have problems relating to continuity of care and legal and other responsibilities. The AMA is also very concerned about those physicians who have contracts with hospitals and medical staff privileges when the contracts are canceled by the hospital administrative board. The House of Delegates voted that the staff privileges of these physicians are still subject to the due process accorded to the other physicians on the medical staff.

With the advent of health insurance companies requiring precertification and demanding limited hospital stays, the work of Reference Committee D of the AMA House of Delegates is becoming more important. Also, the Joint Commission on Health Care Organizations has drastically changed its method of approaching problems related to the hospital and hospital medical staff. Fiscal concerns and viability of hospitals are a major factor in the practice of medicine today, and this is especially true in smaller communities with small local hospitals.

The House voted that all hospital medical staffs should have in their bylaws a mechanism to address impaired physicians and deal with these individuals.

It is incumbent upon us as members of the Kentucky Medical Association and the American Medical Association to be aware of problems related to hospitals, and I invite your concerns related to specific problems of your hospital medical staff to be brought to the KMA House of Delegates so that we may, in turn, present these to the AMA House when appropriate. It is the responsibility of your Delegates to the AMA to represent you, but we can only do this by knowing of your problems and wishes.

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Regional Cholesterol Screening: Problems and Potentials

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Mass cholesterol level screening was carried out in 3,288 individuals. Over a wide range of ages, moderate or high risk values were found in 16%. Follow-up of those with abnormal cholesterol levels revealed that a low percentage visited their family physicians. Moreover, successful responses to treatment were identified in a very small number. The cost of lowering an elevated serum cholesterol level identified in this manner was approximately $800. Problems and potentials of this approach are discussed.

Interest in serum cholesterol level control and understanding of its importance have greatly increased. Patients and physicians have become more well informed as a result of the Lipid Research Clinics-Coronary Primary Prevention Trial (LRC-CPPT)[1] *and recent guidelines proposed by the National Heart Lung and Blood Institute (NHLBI).*[2] *As a result of these reports, it is now recognized that lowering an elevated cholesterol by 1% causes a 2% reduction in mortality from coronary artery occlusive disease. Moreover, it is now conceded that normal levels are much less than had been thought previously and it is recommended that all adults receive treatment to maintain a serum cholesterol less than 200 mg/dl.*

We were recently invited to present an exhibit in the high technology area of the Kentucky State Fair. This provided an opportunity to develop and test the mass screening process, collect data, and to evaluate the cost-effectiveness of such screening processes.

Methods

People who wished to have cholesterol levels determined were given an explanation of the procedure and its purpose. They were asked to sign a permission form while waiting. In addition, the participants completed a triplicate form to determine age, sex, their addresses and those of their family physicians. When the test was completed, the cholesterol level was entered on the form and the individual was given the first copy. A second copy was mailed to the family physician and a third copy retained for data analysis and follow-up. Each participant was told that this cholesterol determination was intended to identify elevated levels and that if a high cholesterol level were found, he or she should undergo additional testing by the family physician. Information was given regarding the long-term effects of serum cholesterol elevation and additional materials on other risk factors were distributed.

An attractive kiosk was constructed which contained multiple interactive video screens. The participants were encouraged to select meals and received printout nutritional analyses which included total calories, protein, saturated and unsaturated fats, carbohydrates, cholesterol, and sodium in the foods selected. These analyses also included recommendations regarding cholesterol and saturated fat consumption by the National Institutes of Health Consensus Panel.

Serum cholesterol testing was done with two Reflotron (Boehringer-Mannheim Diagnostics, Indianapolis, IN) dry chemistry analyzers for whole blood. These reflectance photometers used chemical reagent inserts to perform analyses on undiluted capillary blood. Testing of these methods and the devices yielded a margin of error of 4%. Following a fingerstick, the participant waited approximately three minutes for the cholesterol level determination. The patient was informed whether the cholesterol level was normal, moderately elevated, or high as defined by National Institutes of Health recommendations (Table 1).

Patients with abnormal serum cholesterol levels, ie, moderately elevated or high, were contacted again 6 months later to reiterate the initial level. They were again encouraged to see their family physicians, if they had not already done so. Between 9 and 12 months after the initial determinations, telephone contact was attempted. A copy of the questionnaire used by telephone was mailed to those who could not be reached. Those who could not be reached were asked to complete and return the questionnaire, which consisted of 21 questions including histories of heart disease and previous cholesterol testing

(Table 3). Comments about the screening process, the follow-up with family physicians, dietary instructions, medications, and responses to treatment were also recorded (Table 4).

Costs were calculated for equipment, printing, and labor, excluding those costs incurred for construction of the exhibit. The follow-up costs were those for telephone calls, mailing expenses, and statistical entries.

Table 1. National Institutes of Health Recommendations* Blood Cholesterol Levels, mg/dl

Age	Recommended	Moderate Risk	High Risk
Under 19	Under 172		
20-29	Under 180	200-220	220+
30-39	Under 200	220-240	240+
40+	Under 200	240-260	260+

*U.S. Department of Health and Human Services

Table 2. Results of cholesterol testing at the State Fair by age groups and risk categories

Age	Total Tested In Age Group	Number At Moderate Risk	Number At High Risk
2-19	69	3	3
20-29	382	45	24
30-39	812	56	50
40-49	718	50	46
50-59	588	37	56
60-69	538	67	50
70-79	144	19	8
80+	10	2	1
	3261*	279	238

*Twenty-seven of the participants not included.

Results

We found widespread public interest in serum cholesterol levels and regional or mass screening. Long lines were present throughout the testing period. Many people waited in line for more than an hour. Interest in the interactive videotapes was moderate; most people were attracted to the cholesterol level testing. Three thousand two hundred eighty-eight cholesterol levels were obtained and subsequently categorized into low, moderate, and high risk, as defined by the Consensus Panel (Table 1).

An analysis of the results in 3,261 people according to age is depicted in Table 2. Age, sex, or cholesterol level value were indeterminant in 27 of the triplicate records. Of the 3,261 participants analyzed, 279 (9%) were found to be at moderate risk and 238 (7%) to be at high risk. Of this random cohort of 3,261 of all ages, 517 (16%) were advised to have a repeat serum cholesterol determination by their family physicians.

Of the 517 participants found to have elevated cholesterol level values, we were unable to contact or obtain information from 92 (18%) because of no responses to attempted telephone contacts or correspondence. As a result, our database of information on participants in the elevated cholesterol level category is derived from 425 people.

Table 3. Follow-up responses in the 425 patients at increased risk who were contacted

	Responses	Number (%)
1.	Never had a heart problem, heart attack, or heart surgery.	331
2.	Had heart surgery before screening.	9
3.	Had a "heart problem" or myocardial infarction before screening.	10
4.	Had a heart attack and heart surgery before screening.	7
5.	Had a myocardial infarction since screening.	2
6.	Had heart surgery since the screening.	1
7.	a. Never had a cholesterol test prior to the screening.	288
	b. Did not know if they had had a previous cholesterol test.	13
8.	Did not see MD and self-prescribed a "diet."	24
9.	Self-prescribed medications/treatments.	11
	a. more fiber 1	
	b. oat bran 4	
	c. garlic 1	
	d. lecithin 3	
	e. fish oil 2	
10.	Patients who changed MD because of perceived lack of concern about cholesterol elevation.	3

Tables 3 and 4 delineate individual responses of the participants. Twenty percent of the patients did not list a family physician. One hundred and seventy-four individuals (41%) visited family physicians as a result of this process. Only 5 of the 425 were asked by their doctors to come in for testing as a result of the information sent to each physician. Of 174 participants who visited their family physicians, 159 (91%) received dietary instructions by the physician or his staff. These instructions varied widely in detail. Only 5 patients were seen by dietitians. Twenty-four (14%) were prescribed oral medications but 6 of these (25%) became non-compliant, within 6 months. Fifty-nine (34%) of the 174 patients who were treated by a family physician did not have repeat cholesterol level determinations. Of those who had repeat determinations, 35 (28%) were not informed of the results, 36 (28%) had a higher level after treatment, 24 (19%) reported levels that were unchanged, and 31 (25%) had lower cholesterol level determinations. These 31 participants represented only 18% of the 174 treated by physicians.

Only 174 of the individuals visited their family physicians after our initial cholesterol screening. As a result, the percentage of the total follow-up group (425) who had dietary instruction, medication, or a repeat cholesterol level determination was 40% of the total. Of the individuals at significant risk who completed the questionnaire, approximately 0.5% were contacted as a result of information sent to the physician, 36% received some form of dietary instruction, 6% were placed on medication, 30% had repeat cholesterol level determinations (one quarter of these were not told the value), and only 7% were known to have attained a lower cholesterol level as a result of the process. Twenty-one of the patients reported comments from the physician indicating a lack of concern regarding the reported cholesterol elevation although all determinations in this category were over 300 mg/dl. Fifty-six comments were obtained from participants with very high cholesterol levels indicating a lack of concern or disbelief.

The equipment costs were in the range of $13,151; printing $600; labor $6,050, for a total of $19,800. Based on these expenditures, a cost of $6.02 per patient tested could be assigned and $38.20 necessary to find a participant with an abnormal cholesterol level. Follow-up increased the total expenditure to $24,500. On the latter basis, for the 174 individuals who visited a family physician, the cost was $140.80 each. And finally, to achieve a lowering of an elevated serum cholesterol level in 31 people, the cost was in the range of $790.32 each. If anything, these first approximate figures are low inasmuch as portions of equipment and personnel services were donated. It is probably more realistic to estimate the necessary costs to lower the serum cholesterol level of one individual in this mass or regional screening context to be in the area of $900 per participant.

Table 4. Follow-up findings in the 174 patients at increased risk who visited family physician

	Responses		Number (%)
1.	Went to see family physician following the elevoted cholesterol test.		174
2.	Were notified by MD to come in for testing as o result of the MD letters		5
3.	Hod diet instructions provided by MD.		159
	a. described law fot/low cholesteral diets	121	
	b. told to eat more or less of one foad categary	9	
	c. told to lose weight	1	
	d. told to "watch" what they ate (cauld not relote specifics)	18	
	e. instructions by telephone	5	
	f. given diet booklet, no instructions	5	
4.	Had instructions by o dietitian.		5
5.	Were ploced an medicotion.		24
6.	Stopped toking medicotion (within 6 months).		6
7.	Tested but were not told octuol cholesterol value.		35
8.	Cholesterol level higher ofter treatment.		36
9.	Cholesterol level same ofter treotment.		24
10.	Cholesterol level decreosed after treatment.		31
11.	Had nat hod a fallaw-up cholesterol test since initiol physicion visit.		59

Comment

There can be no doubt that there is increasing public interest in the significance of elevated serum cholesterol levels. Increased education of physicians as a result of the LRC-CPPT results[1] and the NIH Consensus Panel recommendations[2] is leading to more effective treatment. The risk of coronary artery occlusive disease and its complications are reduced when elevated cholesterol levels are lowered. There is no sharply delineated limitation of these benefits. In fact, in the adult population, linear progressive improvement may occur as the serum cholesterol level decreases to 170 mg/dl. This is particularly true if other risk factors are present and are treated simultaneously.

Regional screening is being considered as a means of detecting the problem in asymptomatic individuals so that effective treatment can be initiated. It can be concluded from our limited study that there are many problems and potentials. Although the mandate from the National Institutes of Health is to provide screening in a responsible manner, there are no established standards for providing this service. Nonetheless, public awareness and acceptance, as well as the possibility of reaching a population thus far untouched by the medical community, gives great incentives. Issues of accuracy, distribution of information, education of potential patients and the medical community, and the provision of responsible follow-up to improve community health care standards are but a few of the questions to be addressed.

Previous experiences with screening in the workplace have indicated that information must be provided prior to undertaking the process. Protection of the privacy of information gleaned is quite important, particularly when screenings are conducted at the place of employment. However, the individual at risk must be informed and directed to his or her own physician or health care service for advice and treatment.

In the present study, all of the patients with abnormal levels were told to visit their family physicians. The physicians were also notified of the results. It is evident from Table 3 that 301 (71%) of the 425 patients contacted and followed had been previously unaware that their cholesterol levels were elevated.

Routine screening of cholesterol levels in physicians' offices, at worksites, or in public locales could reduce this number. However, despite the finding of an elevated serum cholesterol level, only 41% of the patients visited family physicians for repeat determinations. Other problems are those of long-term compliance with therapy as indicated by the fact that 6 of the 24 patients placed on medication stopped within 6 months. Moreover, a high percentage (34%) had not had a repeat cholesterol test after the initial visit to the physician. In addition to the lackluster individual response to the finding of an elevated cholesterol value, less than optimal compliance with treatment, and failure of the physicians to perform follow-up cholesterol level testing, the response to treatment was less than adequate among those who were rechecked. Of 91 participants who knew the results of the second determination, 36 were found to have higher levels (40%), 24 were unchanged (26%), and only 31 (34%) had decreased serum cholesterol levels after treatment. Fully two-thirds (66%) of the patients had unsatisfactory responses to treatment, at least at the initial follow-up evaluation. It is apparent that there is significant room for improvement in all of these areas.

Personnel and financial commitments required for mass screening are other important considerations. In this study, the screening process cost approximately $40 to find each patient with an elevated serum cholesterol level, $140 for each patient who visited his physician, and at least $800 to lower an elevated serum cholesterol level that was found as a result of the screening process. Longer-term studies will be required to determine how many of these patients maintain such lowering of the level and continue to adhere to dietary restrictions. Concomitant control of other risk factors such as diabetes, hypertension, and cigarette smoking is also required; each of these factors can double the risk of an elevated serum cholesterol.

This mass cholesterol screening study provides some answers and raises many questions. It is apparent that screening can be effective and that people are receptive to the concept. A high percentage of individuals at significant risk will be found, probably between 15% to 20%. We should strive, however, to eliminate weaknesses of the process by (a) increasing the percentage of the total population who are aware of their specific serum cholesterol values; (b) having a larger percentage visiting their physicians; (c) eliciting more well-informed and aggressive responses by the physicians visited; (d) initiating increasing percentages of effective treatment reg-

imens; and (e) looking toward better long-term compliance with prescribed medications. Less than optimal results in all of these areas were found in this limited study.

Cost of regional or mass screening are not insignificant. If one believes that such screening has educational value which raises public awareness of the problem, then it costs only $6 per individual. Conversely, if one believes that such screening primarily has therapeutic value, then it costs more than 100 times as much. It can also be concluded from our observations that unless more individuals choose to seek treatment and the medical community becomes more aggressive, the benefits of such screening processes will be relatively low and the cost quite high. Nonetheless, repeated exposure to such screening processes ultimately should produce the desired results.

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2. National Cholesterol Education Program Adult Treatment Panel: Cholesterol treatment recommendations of adults. National Heart, Lung, and Blood Institute, draft October 5, 1987.

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References

1. *USP DI Update, September/October 1988, p 120.*
2. *Br J Clin Pharmacol 1985;20:710-713.*
3. *Data on file, Lilly Research Laboratories.*
4. *Scand J Gastroenterol 1987;22(suppl 136):61-70.*
5. *Am J Gastroenterol 1989;84:769-774.*

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Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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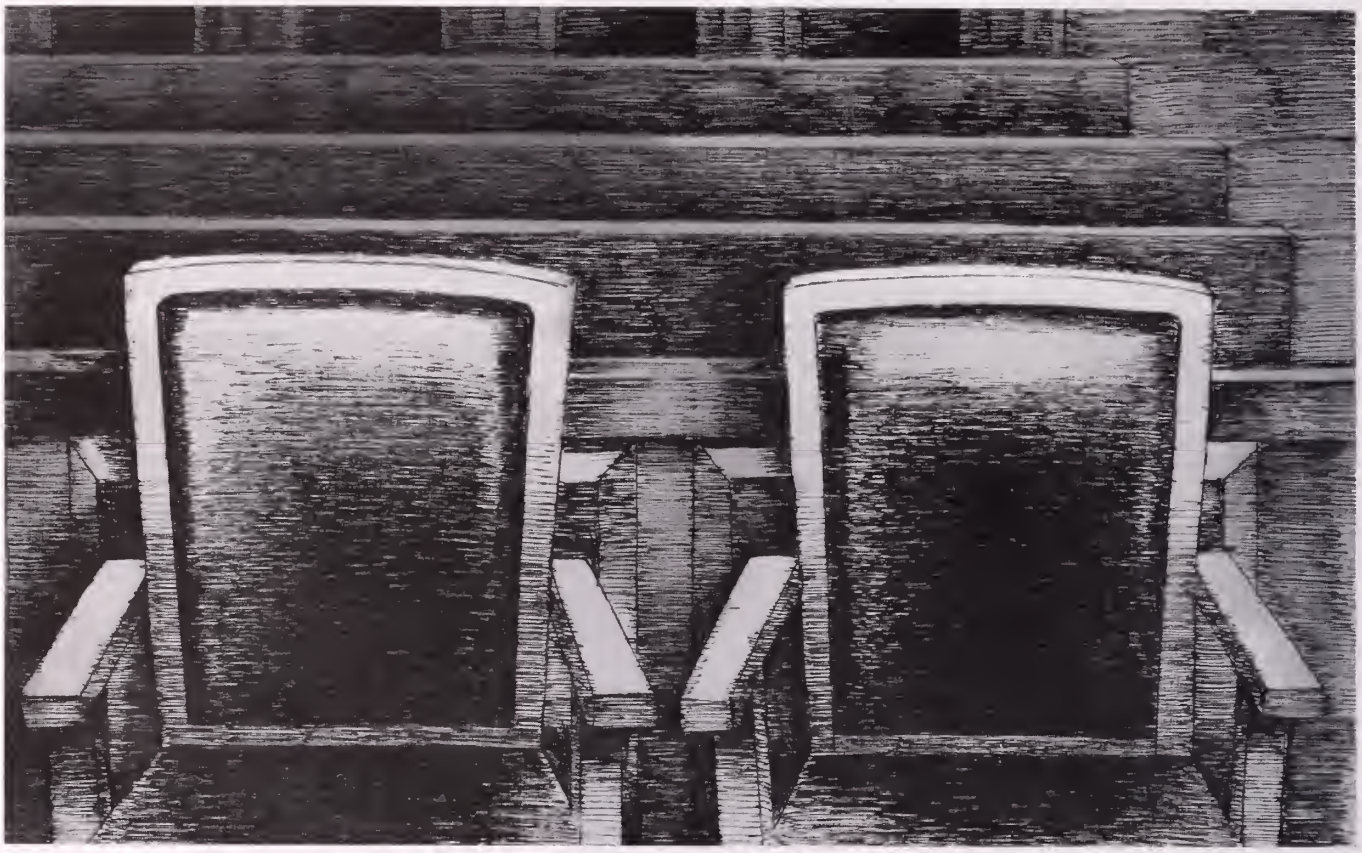

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An Update on Chronic Sinusitis

Welby Winstead, MD

The management of chronic sinus disease has been revolutionized by the application of computed tomographic (CT) imaging and rigid endoscopes in diagnostic evaluation and surgical treatment. These diagnostic advances have led to a better understanding of sinus pathophysiology and the development of more rational surgical treatment. Obstruction of mucociliary drainage in the anterior ethmoid sinus-middle meatus region (ostiomeatal complex) is now understood to be the cause of chronic symptomatic sinus disease. Involvement of the maxillary or frontal sinus is usually secondary to disease in the ostiomeatal complex. Three cases are presented to illustrate the use of CT scanning and nasal endoscopy in the evaluation of chronic sinusitis. Precise identification and correction of ostiomeatal complex obstruction with endoscopic surgical techniques has proven efficacious and is associated with minimal patient morbidity. Endoscopic sinus surgery is emerging as the treatment of choice for medically unresponsive chronic sinus disease.

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Introduction

Disorders of the nose and paranasal sinuses represent one of the most prevalent chronic conditions in this country.[1] Estimated to affect 1 in 5 Americans, these diseases rarely cause mortality; however, they do exact a significant toll by adversely impacting on the disposition, efficiency, and productivity of affected individuals.[2] Despite the prevalence and significant morbidity associated with chronic sinus diseases, evaluation and management are problematic.

Chronic sinus disease is not well defined. Generally, chronic sinusitis is recognized as recurring episodes of acute sinusitis, or symptomatic sinus disease lasting longer than 3 months. More specific classifications, based on predisposing factors or pathogenic mechanisms have been attempted by numerous authors; however, none have gained wide clinical acceptance. There are no pathopneumonic findings on clinical or laboratory examination nor symptoms which distinguish between the varied causes of chronic disease.

Efforts to establish an accurate diagnosis are usually complicated by multiple predisposing factors in individual patients. Not infrequently, the patient with allergic disease will be found to also have vasomotor instability, intercurrent infection, anatomic deformity, or general aggravation of problems by the excessive use of topical decongestants.

Many patients with chronic sinusitis have some degree of facial pressure, pain, or a sensation of obstruction. These symptoms may help distinguish nasal from sinus disease since chronic nasal disease is less frequently associated with pain. Although pain or pressure is usually present, the clinical picture in chronic sinusitis may be dominated by nonspecific symptoms. These include headache, aural pressure, sore throat, lightheadedness, or generalized fatigue and, when present, pose a challenging differential diagnosis.

There is no direct way to visualize the paranasal sinuses on physical examination. Since they are in direct communication with the nose through ostia, the appearance of the nasal mucosa as well as the quality and quantity of secretions is used to infer the state of the sinuses. In this regard, the area of the nose where the sinus ostia open should be subjected to the most intense scrutiny. The frontal, maxillary, and anterior ethmoid sinuses drain secretions into the middle meatus, an area of the nose that is poorly seen on anterior rhinoscopy even when peformed with an operating microscope or flexible endoscope.

Information gained from physical examination is usually supplemented with sinus radiographs. Plain films may be adequate for evaluation of the larger maxillary, frontal, and sphenoid sinuses, which consist of a relatively large cavity with a single ostium. In contrast, the ethmoid sinus is composed of a labyrinth of 3 to 15 small, highly variable cells with capricious pathways of drainage. When superimposed on plain radiographs, these irregular cells are usually poorly defined. Focal inflammation or localized anatomic deformity involving the anterior ethmoid

sinus may be grossly underestimated when evaluated with plain radiographs.[3]

Pathophysiology

The applications of rigid endoscopes and computed tomographic (CT) scanning in the evaluation of chronic sinus disease has revolutionized our understanding of pathophysiology and improved treatment of medically unresponsive disease.

With rigid endoscopes, the critical area of the nose into which the frontal, maxillary, and anterior ethmoid sinuses drain can be seen directly. This middle meatus-anterior ethmoid sinus region (ostiomeatal complex) is the key to understanding sinus disease. Secretions from both the frontal and maxillary sinuses must pass through the anterior ethmoid sinus to gain access to the nose. Disease in the anterior ethmoid sinus-middle meatus region may disrupt normal drainage and ventilation of the maxillary or frontal sinus and precipitate disease.

Normal sinus function is dependent on ostial patency, mucociliary clearance, and the characteristics of nasal mucous. Pathologic alteration of any one of these factors may initiate a sequence of events that leads to inflammatory disease. The importance of ostial closure in the development of sinus disease has been long recognized. The pioneering work of two European researchers, Messerklinger[4] and Stammberger,[5] emphasized the equally important mucociliary clearance function in pathogenesis of disease. They found that disruption of mucociliary clearance in the ostiomeatal complex (OMC) is a frequent cause of inflammatory disease in the dependent maxillary or frontal sinus. Messerklinger documented that contact between two surfaces lined with ciliated epithelium impedes normal clearance, causes stasis of secretions and local inflammation. If this contact is persistent, inflammation may spread to involve adjacent areas, and the mucosa may undergo metaplastic change characterized by hypersecretion of viscous mucous, cellular infiltration, and dysmorphic changes in ciliated cells. The loss of normal ciliated epithelium fuels the cycle which leads to further chronic disease.

The OMC is characterized by narrow fissures and highly varied air cell development predisposing the area to localized inflammatory change.[5,6] In addition, it is the site where most particulates in the inspiratory air are deposited in the nose, sustaining the brunt of toxins, allergens, and pathogenic organisms. The OMC has long been recognized as the most common site for inflammatory disease involving the sinuses, the development of nasal polyps, and malignant transformation after exposure to nickel or wood dust.[7]

Diagnosis

Our ability to diagnose disease involving the OMC has been dramatically improved by the combined use of nasal endoscopy and high resolution coronal computed tomography.

Nasal endoscopy is now routinely performed in the evaluation of chronic sinus disease. This consists of an office examination easily done under local anesthesia. The endoscopes allow a commanding view of the detailed anatomy of the nose and nasopharynx and recognition of focal inflammation or stenosis in the OMC which may cause disease.

CT scanning is used in conjunction with nasal endoscopy to visualize the interior of the sinuses and other areas inaccessible with the endoscope. Applying specific techniques such as high resolution coronal scanning, magnification, and special windowing, CT scanning has significantly improved imaging of anatomy and pathology in the OMC.[8] Contrast enhancement is not required, limiting the exposure to ionizing radiation. CT scanning has also provided definition of anatomic variation that may predispose to chronic inflammation. Complemented with information gained at nasal endoscopy, the cause of chronic sinus disease in many patients has been identified.

The following cases are presented to help illustrate current management of chronic sinus disease based on these improved diagnostic capabilities.

Case Reports

Case 1

A 57-year-old female was referred for evaluation of chronic sinusitis. She had a 15-year history of chronic, bilateral, frontal headache, facial pressure, and retro-orbital pain. She reported trouble with congestion, however noted no problems with nasal airway obstruction or discharge. Multiple bouts of acute sinus infection had occurred over the course of her illness and seemed to exacerbate the pain. She had seen numerous otolaryngologists and had tried multiple medical

regimens including long-term high-dose antibiotic therapy and topical intranasal steroids without lasting relief. Recently obtained sinus films were reported as normal.

Remarkable physical findings were limited to those noted on nasal endoscopy. There was enlargement of both middle turbinates with resultant impaction in the middle meati. Generalized atrophic mucosal changes were evident; however, no mucopurulence, granulations, or hyperplastic mucosal disease was present.

The significant findings on the coronal CT scanning are shown in Fig 1. There was marked pneumatization of the middle turbinate bilaterally which resulted in appreciable narrowing of the middle meatus region as well as impaction along the nasal septum. There was no opacification of the maxillary or ethmoid sinus and little hyperplastic mucosal disease.

Bilateral endoscopic ethmoid sinus surgery was performed with resection of the lateral lamina of both conchae. On both sides, the bulla and anterior ethmoid cells were free of disease and, therefore, further ethmoid dissection was not performed. Blood loss was less than 25 ml. On discharge home, several hours after surgery, the patient reported diminished pressure and headache as compared to her preoperative situation. Her postoperative course was unremarkable, and over the ensuing two years of follow-up, she had no recurrent difficulties with pressure, pain, or acute inflammatory episodes.

Fig 1 — Coronal CT scan through the anterior ethmoid sinus region demonstrating pneumatization of the middle turbinates bilaterally (*). This anatomic variation, also known as concha bullosa, may obstruct mucociliary clearance and cause paranasal pain. Also note the nasal septum (S), inferior turbinate (B), and maxillary sinus ostium on the left (arrow).

Discussion

This patient was an ideal candidate for functional endoscopic sinus surgery because her disease was caused by a localized anatomic variation. When pneumatization of the middle turbinate (concha bullosa) is extensive, it causes persistent mucosal impaction and disruption of mucociliary clearance in the OMC. Surgical treatment of this patient's concha bullosae resulted in complete relief from symptoms.

The cause of her disease escaped identification until she underwent coronal CT scanning. The concha bullosa is a relatively subtle anatomic variation which cannot be visualized on plain sinus films. In addition to concha bullosa CT has allowed definition of a variety of previously unrecognized anatomic variations which may compromise ventilation and drainage in the OMC and cause chronic disease. Included are laterally bent (paradoxical) middle turbinate, Haller cell, enlarged ethmoid bulla, uncinate process deviation or bulla, and agger nasi cells. None of these variations are demonstrated with plain radiographs.

CT in the coronal projection has become the imaging modality of choice in the evaluation of chronic sinus disease. Imaging is optimally performed after the patient has completed a course of intensive medical therapy. Subtle anatomic deformity and irreversible mucosal disease is best identified in the absence of acute inflammatory change.

Headache or facial pain of paranasal sinus origin is thought to be due to mechanical stimulation of unmyelinated C-fibers caused by mucosal contact. In this patient, mucosal contact was caused by the concha bullosa deformity. Stammberger[5] has suggested that substance P-like neuropeptide mediated reflexes are involved in central pain perception as well as local

increase in receptor sensitivity.[9] It is through increased receptor sensitivity that localized disease can cause significant symptoms. These theories regarding the etiology of paranasal pain are supported by the studies of Wolff[10] who demonstrated that mucosa in the OMC is the most pain sensitive of any in the nose or paranasal sinuses.

Pain associated with paranasal sinus disease is usually dull, deep, aching, and nonpulsatile. The pain may be felt locally, but is often referred to areas supplied by the opthalmic division of the trigeminal nerve, with medial canthal, orbital, and frontal distributions. Many individuals will note associated sensations of pressure, fullness, or obstruction.

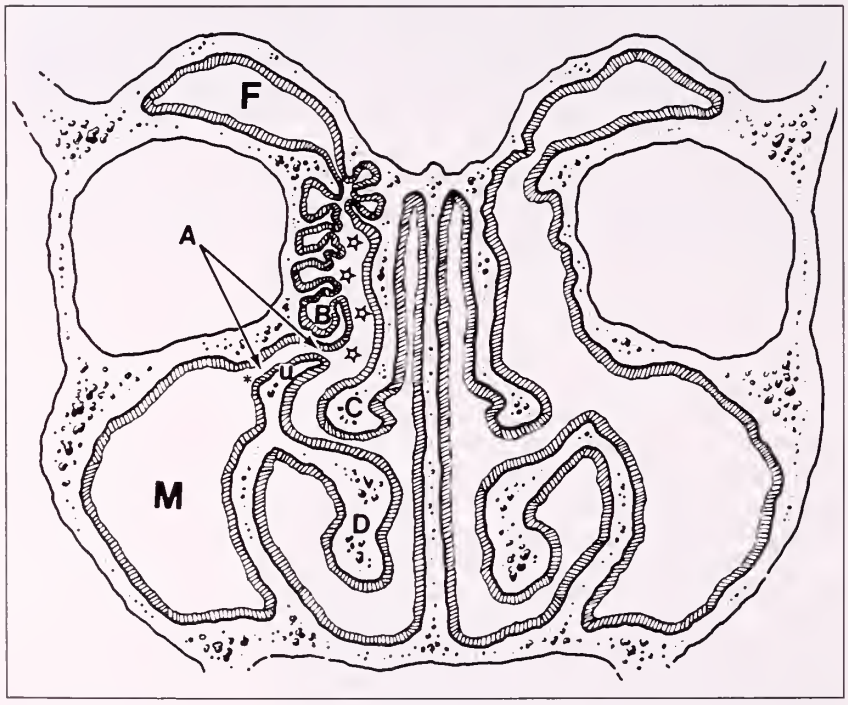

Fig 2 — Schematic diagram of the anterior ethmoid sinus-middle meatus region (ostiomeatal complex) in the coronal projection. On the left, the middle meatus (four stars) receives drainage from the ethmoid bulla (B) and other anterior cells. Secretions from the frontal sinus (F) must pass through the ethmoid region, and maxillary sinus (M) secretions must pass through the ostium (*) and infundibulum (A) before reaching the middle meatus. The situation after functional endoscopic ethmoidectomy is shown on the right. The uncinate process (U) has been removed, the anterior ethmoid cells opened, and the natural ostium of the maxillary sinus widened. The middle turbinate (C) is left intact. Also shown is the inferior turbinate (D).

Endoscopic sinus surgery is individualized to address the specific deformities noted on preoperative endoscopy and CT scanning. The general philosophy is functional; tissue removal is limited to areas of disease while normal anatomy and physiologic function are preserved whenever possible (Fig 2). It is this functional approach to disease based on precise diagnosis that has resulted in less morbidity than standard sinus procedures.

Functional endoscopic ethmoidectomy is indicated for recurring episodes of acute sinusitis or chronic symptomatic disease unresponsive to appropriate medical therapy. Those symptoms which most frequently lead to surgical treatment include pressure, pain, and headache. Endoscopic techniques are contraindicated for intracranial complications of sinus disease. Relative contraindications may include massive polyposis and absent anatomic landmarks secondary to disease or prior surgery.

Routinely, endoscopic sinus surgery is performed on an outpatient basis under either local or general anesthesia. I have found that both patient and physician are more comfortable when the procedure is done under general anesthesia and have not encountered problems with the excessive bleeding. Depending on the extent of disease, the procedure may last from 20 to 40 minutes for each side. Nasal packing is seldom required postoperatively. Typically, there is little discomfort after endoscopic surgery, as illustrated by this patient.

Since wide exoneration is not performed, routine postoperative debridement is an integral aspect of endoscopic sinus surgery. Two or three times within the first week after the procedure, it is necessary to remove clot, fibrinous debris, and retained secretion from the anterior ethmoid to prevent adhesions and recurrent obstruction. Adjunctive medical therapy with antibiotics or topical steroids are occasionally required to promote normal healing. Patients are able to return to work and usual activities after one week.

Potentially serious complications may develop during endoscopic ethmoid sinus surgery if the lateral sinus wall or roof is violated. These include diplopia, blindness, and cerebrospinal fluid rhinorrhea. Precise definition of anatomic variation provided by the CT scan and outstanding intraoperative visualization furnished by endocopic techniques have contributed to the less than 1% reported incidence of serious complications.[5] Endoscopic sinus surgery, however, is technically

challenging and laboratory training is highly recommended before attempting these procedures in the complex and variable anatomy of the anterior ethmoid sinus.

Case 2

A 27-year-old male with allergic rhinitis had adequate symptom relief with oral antihistamine-decongestant preparations and immunotherapy for several years before his referral for evaluation of persistent nasal obstruction. He had developed right-sided nasal airway obstruction over the course of three or four months without associated difficulties with infection, pressure, or pain.

Nasal endoscopy revealed generalized edema and a pale discoloration of the nasal mucosa. Multiple nasal polyps were found on the left arising from the region of the middle meatus and obstructing the nasal airway. No polyps were identified on the right after careful endoscopic examination.

CT scan revealed opacification of the anterior ethmoid and maxillary sinuses on the left (Fig 3). The soft tissue density extends into the nose, consistent with the polyps noted on endoscopic examination. There was no evidence of bony erosive change or expansion. The OMC was free of pathology on the right.

Left endoscopic sinus surgery was performed to relieve the patient's symptomatic airway obstruction and to obtain a histologic diagnosis. This patient's polyps were removed at their site of origin under direct visualization. The maxillary sinus was opened in the middle meatus near the natural ostium revealing a large amount of retained mucoid material. Maxillary sinus endoscopy was performed with inspection and biospy of antral mucosa. There was generalized hyperplastic mucosal changes but no polyps in this sinus. Final histologic diagnosis was allergic, inflammatory polyps of the ethmoid sinus and nose.

Fig 3 — Coronal CT scan through the ethmoid region demonstrating abnormal opacification of the left nasal cavity, ethmoid sinus, and antrum. There is no mucosal disease on the right.

Discussion

Unilateral sinus disease should raise suspicion of neoplasm, foreign body, or dental disease. Histologic diagnosis is indicated in the presence of unilateral polyps to rule out malignancy.

The pathology in this patient could be approached by (a) simple nasal polypectomy, (b) intranasal ethmoidectomy, or (c) endoscopic sinus surgery. Since polypoid disease is frequently recurrent, removal of polyps at their usual site of origin in the ostiomeatal complex is preferred for long-term relief, making polypectomy the least desired. Unlike endoscopic sinus surgery, intranasal ethmoidectomy has historically been performed without the benefits of either intraoperative endoscopic visualization or knowledge of anatomic variation provided by CT scanning. Without the use of these tools, patient morbidity is increased by trauma to normal structures, significant blood loss, and typically nasal packing for five to seven days postoperatively. The reported 2.8% incidence of complications[11] is greater than that reported for endoscopic sinus surgery performed by experienced surgeons.[5]

With the use of a special trocar and cannula, the contents of the maxillary sinus were inspected and biopsied without the need for Caldwell-Luc antrostomy and its attendant morbidity.

Intranasal antrostomy was established in the middle meatus because natural mucociliary clearance is towards this area. The naso-antral window, an intranasal antrostomy created in the inferior meatus, ignores the importance of this natural pathway of sinus drainage and should have

a very limited role in the surgical treatment of chronic sinus disease despite widespead use in the past. Kennedy[12] has shown that OMC disease causes chronic symptomatology even in the presence of widely patent inferior meatus windows.

In patients with allergic disease and other forms of nasal mucosal sensitivity of unknown etiology, optimal long-term management includes aggressive medical therapy. This principally involves topical intranasal steroid sprays and varying combinations of expectorants or decongestants given orally. Saline nasal sprays have a mild decongestant effect and are helpful in many patients.

Case 3

A 34-year-old male presented for treatment of chronic sinusitis. He reported numerous bouts of acute infection requiring prolonged antibiotic therapy for resolution. In addition, he had near persistent problems with facial pressure, headache, severe generalized fatigue, and lightheadness. His initial evaluation by an internist included sinus films that were reported as normal. Further evaluation of his headache included normal CT scan of the brain and electroencephalogram. Routine laboratory diagnostic studies were also performed and within normal limits. Ear, nose, and throat evaluation included coronal ethmoid CT scanning and nasal endoscopy. CT scanning revealed no deformity or hyperplastic mucosal change in the OMC. A minimal amount of retained secretion was present in the right antrum. Nasal endoscopy revealed edematous mucosa in the right hiatus semilunaris with viscous, yellowish secretions. No stenotic change or mucosal edema was present on the left in the middle meatus.

This patient was placed on a medical regimen that included an initial 3-week course of broad-spectum antibiotics, as well as topical intranasal steroid spray, expectorants, and saline nasal sprays. The patient obtained no relief from his pain while on this regimen and developed purulent drainage shortly after completing his course of antibiotics. He underwent functional endoscopic ethmoid sinus surgery bilaterally. At the time of the procedure, isolated cells in the right frontal recess area revealed hyperplastic mucosa. Some modest crowding of cells in the middle group on the left was also noted. Postoperatively, there was decreased severity and frequency of many of his chronic symptoms; however, recurrent infection has occurred.

Discussion

This patient demonstrated some of the continued difficulties in management of chronic sinus disease despite major advances in diagnostic capability. The absence of obvious anatomic deformity or variation on the CT scan does not rule out symptomatic sinus disease. Distinguishing normal variations from deformities that may cause physiologic dysfunction is not always possible radiographically. Conversely, 30% of asymptomatic adults were found to have coincidental ethmoid sinus disease on CT scans, according to a recent study.[13] An abnormal CT scan is not an indication for surgery nor is a normal scan an absolute contraindication. The clinician must synthesize information from the patient's history, findings on endoscopic examination, and results of CT scanning to formulate appropriate strategies for management. Careful clinical judgment and meticulous surgical technique will help minimize unsatisfactory results.

Persistent symptoms are the most frequent complications after endoscopic sinus surgery. These may be due to incorrect diagnosis of the problem, ineffective surgical drainage, poor postoperative debridement, or recurrent disease.

Conclusion

The development of endoscopic techniques has revolutionized the diagnosis and treatment of chronic sinus disease. Along with coronal CT scanning, endoscopic techniques have led to an improved understanding of sinus pathophysiology. They provide the ability to define the cause of chronic disease in many patients and allow precise surgical correction with minimal morbidity.

Obstruction in the ostiomeatal complex is the cause of most chronic sinus diseases. Involvement of the maxillary or frontal sinus is usually secondary to disease in the anterior ethmoid sinus. Reestablishing drainage in the ostiomeatal complex often results in relief of symptoms attributed to the maxillary or frontal sinus. Surgical procedures that ignore the importance of the ostiomeatal complex, such as the Caldwell-Luc antrostomy and nasoantral windows, should assume a limited role in the treatment of chronic sinusitis.

Endoscopic sinus surgery is based on this improved understanding of sinus pathophysiology. It emphasizes precise diagnosis and main-

tenance of normal physiology by removing only diseased tissues under direct visualization. This endoscopic approach has resulted in improved efficacy and decreased patient morbidity.

Surgical treatment must be based on a careful synthesis of information obtained from history, endoscopic examination, CT scanning, and response to intensive medical therapy. A detailed knowledge of the complex anatomy of this region and experience with endoscopic techniques are essential if potentially serious complications are to be avoided.

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JCMS Outreach Program Establishes the

Will W. Ward, Jr, MD

The John H. Morgan Center was established on December 13, 1989, when the Jefferson County Medical Society (JCMS) Outreach Program, Inc. assumed ownership and operation of the properties at 1017, 1019, and 1020 West Market Street, which had been previously operated by Mission House, Inc. as shelters for homeless men. The center was so named to honor Father John H. Morgan, a Catholic priest who founded Mission House, Inc. in the Spring of 1971 as a nonprofit organization funded by private donations. Its purpose was to provide basic human needs to Louisville's street people, the homeless, destitute, and distressed who are the poorest of the poor. Father Morgan has been a Louisville pioneer in providing services to the homeless, and the December 13 ceremony honored him for his tireless efforts that had seen Mission House grow to be the city's largest shelter for homeless men. Paying tribute at the ceremony honoring Father Morgan for his many years of dedicated service were the Most Reverend Thomas C. Kelly, OP, Archbishop of Louisville; Jefferson County Judge Harvey Sloane, a member of the Jefferson County Medical Society; Judge Elect Dave Armstrong; US Congressman Romano Mazzoli; Harry Cowherd, MD, secretary of the Cabinet for Human Resources; as well as many friends, supporters, and members of the Jefferson County Medical Society and its Auxiliary. The facility at 1020 West Market Street was completed in June 1985 with donated labor and materials through the generosity of more than 120 builders coordinated by Jesse Bollinger, a Louisville developer.

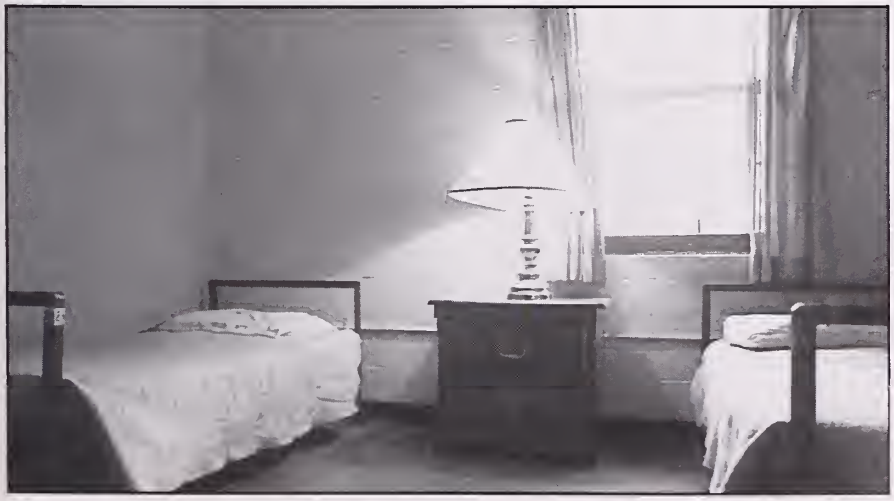
The most exciting activity of the Morgan Center and Outreach Program is the research and development of permanent solutions to the continuing problem of homelessness.

The initial activity of the JCMS Outreach Program has been the continuation and expansion of existing services. These include nightly shelter for 160 men, serving 10,000 meals monthly, operating a soup kitchen, day center, medical clinic, clothing room, and laundry room. The medical clinic's regular weekly hours have been expanded and a mental health clinic has been established. These clinics are regularly staffed by members of the Jefferson County Medical Society. In addition to general medical services, specialty care is also volunteered by society members. Nutritious meals and efficient use of donated foods and government commodities are planned by the Louisville chapter of the Kentucky Dietetic Association. Health assessment and education is provided by the University of Louisville's School of Nursing and the Kentucky Nursing Association. The Louisville Dental Society, Kentucky Podiatric Medical Association, Jefferson County Optometric Society, Jefferson County Academy of Pharmacy, and Kentucky Society of Certified Public Accountants are also cooperating with the Outreach Program.

The most exciting activity of the Morgan Center and Outreach Program is the research and development of permanent solutions to the continuing problem of homelessness. The home-

Facing page: Many homeless men seek shelter at the Center. Though sparsely furnished, the basic human needs of Louisville's "street people" are provided by the Center.

John H. Morgan Center for the Homeless



Jefferson County Medical Society Outreach Program

It is a unique and innovative cooperative venture bringing together previously untapped community resources in an attempt to help solve one of our most pressing social problems.

less population grows steadily, and existing programs have not kept pace with the needs. By bringing new people, new ideas, and new energies into the field, the Outreach Program hopes to mobilize a broad front of community groups and individuals into a search for programs that will return some of the homeless to useful and contributing roles in the community. Through the active participation of the University of Louisville's College of Urban Affairs and Kent School of Social Work, research, development, and study of the efficacy of social programs are a major thrust of the work. The entire organization and its development is designed to be a model which other communities are encouraged to emulate. This information is made available to individuals or groups desiring to start programs to help the homeless and needy.

The JCMS Outreach Program, Inc. is a 501(C)3 organization established by the Jefferson County Medical Society in 1989. As such, all contributions are tax exempt.

A. O'Tayo Lalude, MD, standing, a Louisville family practitioner, and G. Randolph Schrodt, Jr, MD, a Louisville psychiatrist, are among the many physicians who volunteer their services at the Center.

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- Barbara Van Meter, Communications Director

The organization is entirely staffed by volunteers and encourages any group or individual to participate in its work with donations of service, goods, money, or any other contributory activities. These can range from something as simple as a "helping hand" to a destitute person to the most sophisticated medical, legal, or accounting service. It is a unique and innovative cooperative venture bringing together previously untapped community resources in an attempt to help solve one of our most pressing social problems. We ask for the help of all — no gift or service is too small, and it may help you find a new sense of comfort in helping the unfortunate.

Gifts and good wishes will be most welcome at the JCMS Outreach Program Office, 101 W Chestnut St, Louisville, KY 40202, (502)584-7844.

THE UNITED STATES ARMY RESERVE

HEALTH CARE PROFESSIONALS BONUS TEST PROGRAM

$10,000 - $20,000 - $30,000

The **1989 National Defense Authorization Act** requires that the Department of Defense conduct a test to determine the effectiveness of a recruitment bonus to attract health care professionals to the Selective Reserve of the Army.

The Bonus Test Program is scheduled to begin on or about August 1, 1989 and will be offered to physicians in the following specialties:

ANESTHESIOLOGY
ORTHOPAEDIC SURGERY
and
GENERAL SURGERY
(Including selected subspecialties)

Applicants must be board certified or meet all requirements for board candidacy in one of the above specialties.

BONUS ELIGIBILITY: In addition to meeting all criteria for appointment as a medical corps officer in the US Army Reserve, Bonus Test applicants must be civilians and if prior service, discharged before 28 April 1989.

BONUS AMOUNTS: The test will offer $10,000 bonus for each year of affiliation with the Selected Reserve of the Army, up to a maximum of 3 years. Physicians must choose 1, 2, or 3 years of affiliation at time of application. Bonuses will be paid annually at the beginning of each year of agreed affiliation.

TEST PARAMETERS: The design of the test stipulates that bonuses be offered in certain geographic areas. To qualify, applicants must reside within those areas at the time of accession.

TO FULLY DETERMINE YOUR ELIGIBILITY FOR THIS PROGRAM PLEASE CONTACT:

ARMY RESERVE HEALTH CARE TEAM
9505 WILLIAMSBURG PLAZA, WASHINGTON BLD., LOUISVILLE, KY 40222-5044. OR CALL:(502) 423-7342 or 7444 COLLECT

Putting Something Back in the Well

'Could other medical societies throughout the state reproduce this type of endeavor? . . . Just one man in each medical society with vision and the ability to galvanize the forces into action is all it would take.'

As a Jefferson County physician it is probably not too wise of me to write about the virtues of physicians in Jefferson County, particularly when writing in a statewide publication. But good sense was never one of my main virtues, so here goes. . . .

In the summer of 1989 the Jefferson County Medical Society developed an Outreach Program to govern, finance, and operate the John H. Morgan Center for the Homeless. This center is a mission home for the less fortunate men of our community who are in need of lodging, food, safe harbor, and medical attention.

This mission and its annex across the street prepare food for 9,000 meals a month and supply overnight lodging for 150 men an evening. The mission has a budget of $95,000 a year, and already $125,000 has been raised through generous donations by many members of the medical society.

Many other disciplines make great contributions to the center. The women's auxiliary supplies clothing. Pharmaceutical companies and doctors donate samples of needed drugs and supplies. Volunteer and student nurses contribute time and effort to the health-education clinics. Professional dieticians help both in planning nutritious meals and finding sources of food donations. Physicians take rotation in staffing a medical clinic in the evenings and see 20 to 25 patients at each session. Psychiatrists staff a mental health clinic and see one or two patients a night. Legal aid has been donated by some lawyers who want a chance to get involved. In the famous words of Jimmy Durante, "Evvvvre-body wants a get inna de act."

When I read of this great success story, I began to wonder. Could other medical societies throughout the state reproduce this type of endeavor? There must be hundreds of people in Kentucky who would like to be one of George Bush's "Thousand Points of Light" and volunteer both money and time to those less fortunate. Just one man in each medical society with vision and the ability to galvanize the forces into action is all it would take.

'Altrusim still remains at the very core of our profession.'

Doctors that I know want to find a way to pay back society for their good fortune. Altrusim still remains at the very core of our profession. The problem is to find an outlet for this need to serve. The fuse is set. Who among us will ignite it?

Milton F. Miller, MD

The AMA
Hospital Medical Staff Section
Fifteenth Assembly Meeting
June 21-25, 1990
Chicago Marriott Hotel
Chicago, Illinois

Highlights of the Annual Meeting will include:

- an educational program entitled, "Building Effective Hospital Physician Relationships: Ten Success Stories"; Stephen M. Shortell, Ph.D. will present the results of his study on the working relationships between ten selected hospitals and their medical staffs;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including the Impact of Hospital Bankruptcy, the Role of Hospital Governing Boards in Professional Review, and Information Sharing Among Medical Staffs;
- recommendation of policy to the House of Delegates on Prioritization of Health Care Expenditures and Notification of Denials by the PRO;
- AMA-HMSS Governing Council elections for the positions of Chairman, Vice-Chairman, Secretary, and one Member-at-large.

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
Phone (312) 645-4754 or 645-4761

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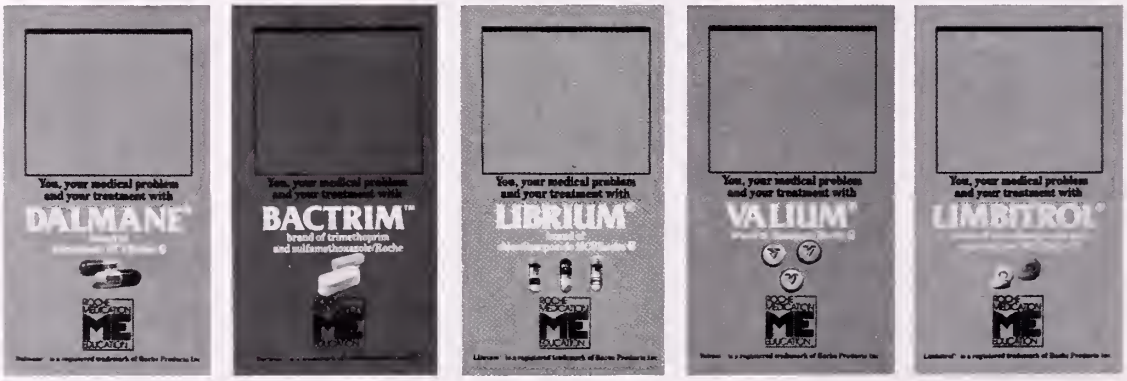
Because you are the primary source of medical information for your patients, we invite you to look over the Roche product booklets shown below. Ask your Roche representative for the new catalog brochure of patient education materials and for a complimentary supply of those booklets applicable to your practice, including the WHAT IF Book in large type.



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CAMC

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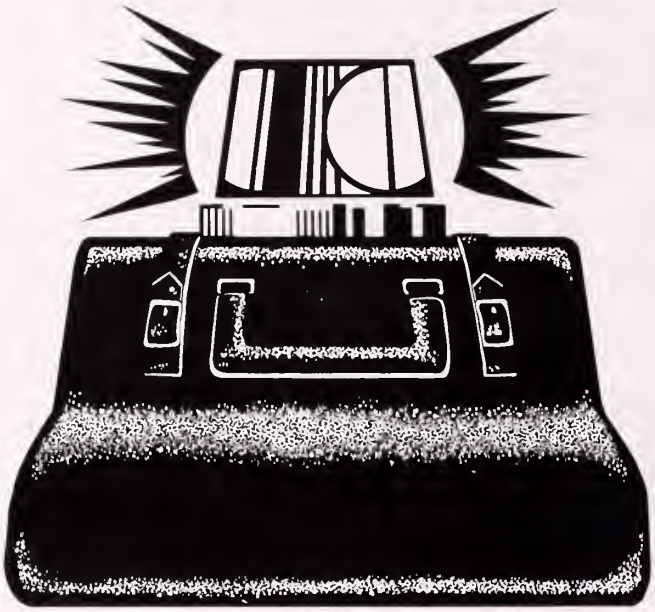
20th Annual



EMERGENCY MEDICAL CARE

Seminar

Lake Barkley State Resort Park
Cadiz, Kentucky
May 8, 9 and 10, 1990

presented by
Kentucky Medical Association

Tuesday, May 8, 1990

Morning Session

Theme *Back to Basics*

7:15 AM	Registration
7:40 AM	Welcome and Orientation
	Opening Remarks E. T. Mays, MD, Chairman, Somerset Emergency Medical Care Seminar Committee
	Moderator Nelson B. Rue, MD, Bowling Green, KMA President
8:00 AM	*Surface Trauma Lacerations — to Suture or not to Suture* Edmond A. Hooker, MD, Louisville
8:30 AM	*Primary Burn Care* Raymond G. Hart, MD, Louisville
9:00 AM	*Surface Trauma Crush Injuries* Gregory C. Vincent, RN, Paducah
9:30 AM	*Open Fractures* Francis L. Buono, MD, Bowling Green
10:00 AM	*Cephalgia vs Drug Abuse* Rick Collier, RN, Cadiz
10:30 AM	**Coffee Break**
10:45 AM	*Water Sports and Injuries* Donna Owsley, RN, Gallatin, TN
11:15 AM	*Current Tetanus and Rabies Prophylaxis* David M. West, MD, Paducah
11:45 AM	*Human Bites* Gregory L. Brown, MD, Louisville
12:15 PM	*What Happens to those Sutures Placed in the ER* Marc L. Holbrook, MD, Lexington
1:15 PM	**Lunch**

Tuesday, May 8, 1990

Evening Session

Moderator Barbara Cox, RN, Louisville

6:00 PM	*Instrument of Fear — Instruments of Need* Charles R. Oberst, MD, Louisville

Wednesday, May 9, 1990

Morning Session

Theme *Sudden Death*

7:15 AM	Registration
7:50 AM	Opening Remarks **Moderator** Barbara Cox, RN, Louisville
8:00 AM	*University of Kentucky Traffic Injury Survey* Marc L. Holbrook, MD, Lexington
8:30 AM	*Sudden Death Syndrome in Infants* Mary A. Smith, MD, Louisville
9:00 AM	*Missle Wounds to the Pregnant Uterus* Terrell D. Mays, MD, Elizabethtown
9:30 AM	*Toxicology* George C. Rodgers, MD, Louisville
10:00 AM	*Priorities of Care for Injured Children* Vicki G. Hardwick, RN, Louisville
10:30 AM	**Coffee Break**
10:45 AM	*Meningitis in Adults* John D. Noonan, MD, Paducah
11:15 AM	*Guns: A Medical Examiner's Prospective* Gregory J. Davis, MD, Louisville
11:45 AM	*Ruptured Thoracic Aorta* Edmond A. Hooker, MD, Louisville
12:15 PM	*Wound Care* Raymond G. Hart, MD, Louisville
12:45 PM	*Alcohol and Substance Abuse* Pat Sisloff, RN, New Albany, IN
1:15 PM	**Lunch**
4:00 PM	**Open Meeting:** KY Chapter, American College of Emergency Physicians

Thursday, May 10, 1990

Morning Session

Theme *Pot Pourri*

7:15 AM	Registration
7:50 AM	Opening Remarks **Moderator** Terrell D. Mays, MD Elizabethtown
8:00 AM	*Pediatric Emergencies* David Miller, MD, Louisville
8:30 AM	*Common Medications in the Emergency Room* Bradford E. Mutchler, MD, Paducah
9:00 AM	*Drips and Pumps* Penny S. Schaftlein, RN, Louisville
9:30 AM	*Sexual Abuse* Patty Sturt, RN, Lexington
10:00 AM	*Sudden Death in Athletes* R. Quin Bailey, MD, Danville
10:30 AM	**Coffee Break**
10:45 AM	*Kids are Different* Diller B. Groff, MD, Louisville
11:15 AM	*Is our Blood Supply Safe* James R. Roush, MD, Louisville
11:45 AM	*Volume Depletion* Wally O. Montgomery, MD, Paducah
12:15 PM	*(To Be Announced)* Burns M. Brady, MD, Louisville
1:15 PM	**Lunch**
1:30 PM	**Open Meeting:** Kentucky Trauma Nurse Core Course Council

Wednesday, May 9, 1990

Evening Session

Moderator Barbara Cox, RN, Louisville

6:00 PM	*AIDS and Universal Precautions in the ER* Ardis D. Hoven, MD, Lexington
8:00 PM	**Open Meeting:** Kentucky Emergency Nurses Association

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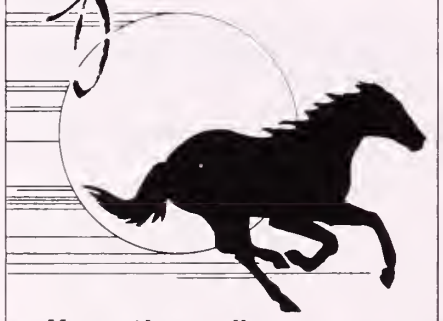
Kentucky *feelings*



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and see all of Kentucky

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THE FIRST PART OF THE BODY THAT MUSCULAR DYSTROPHY AFFECTS.

It's hard to smile when you lose the ability to walk. To play. To draw pictures. To climb a tree.

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"Muscular dystrophy" is the name for a group of diseases that weaken and destroy the muscles. The disorders are progressive, so things get worse over time. The muscle loss can't be stopped. And it can't be reversed.

The Muscular Dystrophy Association is striving to cure muscular dystrophy. And on Christmas Eve of 1987, MDA researchers announced a landmark advance: discovery of the cause of the most terrible form of muscular dystrophy, *Duchenne*.

Now a giant step toward curing these dread diseases has been taken. And MDA researchers are forging ahead, racing to save the children stricken today.

MDA receives no government grants or fees for services — its work is funded entirely by private donations. You can help MDA fight muscular dystrophy and dozens of other muscle diseases by sending a tax-deductible contribution today.

Don't wait until a child's smile reminds you of all the children who have *stopped* smiling. Please send your donation today.

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Muscular Dystrophy Association
Jerry Lewis, National Chairman

To make a donation or bequest to MDA, to receive an annual report or to obtain more information, write to: Muscular Dystrophy Association, 810 Seventh Avenue, New York, NY 10019. Or contact your local MDA office.

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The year has swiftly come and gone, and it is time to reflect and assess where we are, as we look forward with excited anticipation to a new auxiliary year to come.

Each auxiliary year is the continuation of a road traveled. Along the way, lives are touched, an impact is made, and never again will things be exactly as they were.

As auxilians, we have made a difference individually and collectively. Needs have been perceived, both in communities and in our state, and we have risen to meet these needs. As allies of the medical profession, we share the common goal of preserving and enhancing quality health care in our state and urging the accessibility of this for all Kentuckians.

We are at a time when medicine is no longer in (to borrow the editorial thoughts of Kathleen Jordan, in the January 1990 AMAA publication of *FACETS):*

> . . . a simpler time when the physician could act on his knowledge and skill without interference or second thoughts, when the patient trusted her physician to the point where she was willing to endure horrendous pain because she knew he had the answer to her problem, when no one talked about who was paying the bill, when no one thought of suing the doctor should the outcome not be good.

Instead, physicians are being forced out of practice by the threat of malpractice and the reality of high insurance premiums, and frustrated by the pressures brought by regulatory changes. In this scenario, it is imperative that the auxiliary become increasingly aware of these changes, occurring in federal and state legislative arenas, which will have a lasting effect on the practice of medicine and health care delivery in general.

Together, we have responded by increasing our knowledge of the legislative process and our awareness of key issues related to medicine. We have learned, too, that support for our members and their families, going through trying situations, is also important, and county auxiliaries are organizing support groups for this purpose.

Sensing community needs, Auxiliary efforts have targeted a wealth of health and societal concerns such as teenage pregnancy, AIDS education, the homeless, prenatal health, the aging population, infant safety, cholesterol testing, organ donation, drunk driving, physical fitness, blood bank programs, and more. In addition, together we have supported Kentucky's Ronald McDonald Houses, raised scholarship money for students embarking on health careers locally and through the AKMA Health Career Fund, and have contributed record amounts to the American Medical Association-Education Research Foundation (AMA-ERF).

In addition, on a statewide basis, the auxiliary endorsed the joint efforts of the American Academy of Family Practice and the American College of Obstetricians and Gynecologists in addressing the problem of teen pregnancy. This resulted in an overture from the Kentucky Cabinet for Human Resources, Department of Family Health Services, to join forces with

'As auxilians, we have made a difference individually and collectively. Needs have been perceived, both in communities and in our state, and we have risen to meet these needs. As allies of the medical profession, we share the common goal of preserving and enhancing quality health care in our state and urging the accessibility of this for all Kentuckians.'

them in targeting 146 Kentucky school districts for distribution of the AAFP/ACOG materials — a feat made possible by working together.

Several awareness projects have also been the result of collaborative efforts during this past year. Due to the interest of the AMA Auxiliary, the cooperation of the KMA, the McDowell House staff, and the diligent effort of Angie DeWeese, McDowell House was featured in a cover story in the January 1990 issue of *FACETS* magazine! This is a wonderful tribute to Kentucky Medical Association and Auxiliary efforts to preserve this valuable bit of Kentucky medical history.

And, for the first time, our state Doctors' Day project will embrace the sponsorship of an essay contest for high school students. Students will be asked to write on "How I View Medical Care in the Year 2000." Through this exercise, students will have an opportunity to investigate the many changes going on in medicine and gain a better understanding of what today's decisions will mean for the health care of future generations.

'Communication, cooperation, and collaboration have been our guide words for this year. It has been a good year. We have reinstituted regional meetings to reach out to our members, with a special effort to reach potential members-at-large in unorganized counties. . . . We have worked closely with the Kentucky Medical Association — their support and encouragement are greatly appreciated.'

Communication, cooperation, and collaboration have been our guide words for this year. It has been a good year. We have reinstituted regional meetings to reach out to our members, with a special effort to reach potential members-at-large in unorganized counties. We have made a concerted effort to extend membership to medical student and resident physician spouses, for these are our auxiliary leaders of tomorrow. And, we have encouraged double physician couples to support the auxiliary. We have worked closely with the Kentucky Medical Association — their support and encouragement are greatly appreciated.

As auxilians, we have made a difference! I am proud of each one of you, for without each individual effort, the successful whole would not be possible. Thank you!

Esther Jansing
AKMA President

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Pride in Medicine

KMA ANNUAL MEETING • SEPTEMBER 24-27 • HYATT REGENCY-COMMONWEALTH CONVENTION CENTER • LOUISVILLE, KENTUCKY

This year's KMA Annual Meeting will be held in downtown Louisville at the Hyatt Regency Hotel and Louisville Convention Center. KMA is looking forward to hosting the meeting on September 24-27, at a location that offers ample meeting and exhibit space along with a variety of sightseeing, shopping, and dining facilities. Louisville is an ideal convention city and ranks among the country's top ten cities in convention attendance. At the same time it ranks the lowest in food and lodging costs.

The March issue of the *Journal* contained information on the Convention Center and hotel. This month we are highlighting a few of downtown Louisville's many offerings for your leisure hours while attending the Annual Meeting.

Shopping and Sightseeing

Downtown Louisville offers a wealth of things to see and do. A few blocks from the Hyatt Regency Hotel and Convention Center is the Museum of History and Science with exhibits of modern technology and ancient history. On display is the Appollo 13 space capsule along with a 2600-year-old mummy, and the IMAX theatre that combines a huge image on a four-story tall screen with a 27 speaker surround sound system. The IMAX theatre system is the only one of its kind in Kentucky, Indiana, and Tennessee. In September, there will be four different films showing in rotation (you can be blasted into outer space in the space shuttle; go inside the human heart; hover above the surface of the earth; or walk on the ocean's floor.) Close to the museum is the Kentucky Art and Craft Gallery featuring works by Kentucky artists. The Gallery has jewelry, pottery, sculptures, and folk art and crafts on display and for sale. One of Louisville's newest attractions is the Louisville Falls Fountain which will be in operation during the meeting. Other downtown attractions include the Kentucky Center for the Arts, Actors Theatre of Louisville, lunch or dinner cruises on the Ohio river aboard the Star of Louisville, the McCauley Theatre, and Louisville Gardens.

Within walking distance is downtown Louisville's historic district with classic architecture that brings history to life. The 19th-century stone and cast-iron buildings on West Main Street are the largest collection in the U.S. outside of New York City. Elegantly crafted storefronts provide a beautiful complement to new office towers and the modern Kentucky Center for the Arts.

Discover the grace of the Victorian era in Old Louisville, the city's first suburb. Developed in the late 19th century, during the period of prosperity that Louisville enjoyed after the Civil War, Old Louisville contains a spectrum of architectural styles. A short drive from downtown Louisville is some of the finest 19th century residential Victorian architecture in the country. The breathtaking display of homes in Belgravia Court and St James Court, which offer turrents, gargoyles and other imposing ornamental designs, will keep you fascinated for hours. Also in Old Louisville are the Conrad House, dating from 1895, and the Brennan House, an opulently furnished, beautifully preserved Victorian townhouse. *kma*

The city's skyline is now enhanced by the Louisville Falls Fountain which will be in operation during the Annual Meeting.

140TH KMA ANNUAL MEETING OFFERS A WEALTH OF ACTIVITIES

Scientific Sessions

The Hyatt Regency Hotel and Commonwealth Convention Center will host the 1990 Annual Meeting. The Scientific Program Committee has invited speakers from across the nation to participate in the sessions to be held during the mornings of September 25, 26, and 27.

Specialty Groups

Programs for 21 specialty groups will be held during the afternoons of September 25, 26 and 27. No general sessions are scheduled during the specialty group meetings and all KMA members are invited. Scientific sessions and specialty group meetings will be held in the Commonwealth Convention Center. By completing CME sign-up sheets at the beginning of each meeting, physicians attending general sessions and specialty group meetings will qualify for Category 1 Credit.

KMA House of Delegates

The opening meeting of the House of Delegates will be held Monday, September 24, at 9 AM in the Regency Ballroom located in the Hyatt Regency Hotel. Reference committee meetings will begin at 2 PM on Monday and the final meeting of the House will begin at 7 PM Wednesday, September 26. Officers for the 1990-91 Associational year will be elected during the final House meeting.

Other Activities

The 28th Annual KEMPAC Seminar will be held Monday evening, September 24, in the Regency Ballroom, located in the Hyatt Regency Hotel. A reception begins at 6 PM with dinner at 7 PM, and the program to follow at 8 PM.

The President's Luncheon will be held September 26 with presentations of KMA awards and the installation of the 1990-91 KMA President, Preston P. Nunnelley, MD.

Scientific and Technical Exhibits will be on display featuring new medical products, services, and techniques. Members and guests have an opportunity to visit this area during the 30-minute intermissions scheduled throughout the general sessions and specialty group meetings.

UPDATES

UK Researchers Report Alcohol Abuse May Have Impact on Severity of AIDS

A team of researchers at the University of Kentucky College of Medicine are working to determine the impact alcohol abuse has on the development of AIDS. Because of the known immunosuppressive effects of alcohol abuse, researchers have reason to believe that excessive use of alcohol may lead to a more severe form of AIDS. The AIDS virus also inhibits the immune system.

According to the University, the most rapidly growing population coming into hospitals with AIDS is chronic drug abusers, who abuse drugs including alcohol. Results of the research could benefit health professionals in determining the health cost that will be generated by this particular group and what to expect in needed treatment. The long-term goal of the study is to determine if these particular individuals are going to be sicker than AIDS patients who do not have a history of alcohol, and if they will require longer hospitalization and more treatment.

While researching the impact of alcohol abuse on the severity of the disease, the researchers plan to study effects of AIDS infection on several aspects of the immune system including the ability of infected animals to synthesize and secrete antibodies and cytokines.

Antibodies and cytokines are major protective proteins secreted by the body during an infection. Cytokines regulate the immune response as well as several other physiologic functions that are altered in the early stages of AIDS. During early stages of infection, the immune system actually turns on causing swelling of the lymph glands. However, there is little information concerning the initial stage of infection. By using a "murine model" (mice) researchers will have the opportunity to study the virus and immune system at the time of actual infection.

The research team reports that it is their goal to understand the biology and immunology of this infection and not their goal to have an impact on the use of alcohol. At the conclusion of the study, they hope to have a detailed evaluation of alcohol abuse as a contributing factor on the development of AIDS in mice, which will put them in a better position to understand the true impact of alcohol abuse on human AIDS.

The research is funded by the National Institute on Alcohol Abuse and Alcoholism.

For additional information or an interview, contact Ellen Razor at (606) 233-6363.

U of L Residents Attempting to Keep Kids in the Classroom Through Better Health

When children don't feel well, they don't learn.

The University of Louisville is addressing this problem through a new program that brings doctors to the classroom.

U of L residents are teaching students at a Louisville middle school how to eat right and stay healthy.

The project also benefits teachers, who learn about health issues, and the residents, who gain experience in dealing with children.

Conference on Appalachian Children at UK

The Appalachian Center of the University of Kentucky will sponsor a Conference on Appalachian Children, November 6-7, 1990, on the UK campus in Lexington. The goal of the conference is to bring together health care workers, social workers, policy makers, academics, parents, educators, and others concerned about a broad range of children's issues. The deadline for submission of paper or panel proposals is **May 7, 1990.** For more information, write Jane Bagby, Assistant Director, Appalachian Center, University of Kentucky, 641 S Limestone St, Lexington, KY 40506-0333, or call (606) 257-4854.

Medicare Book Available From Fayette County Medical Society

A limited number of "Selected Medicare Provider Numbers in Kentucky 1989-90" are available at the Fayette County Medical Society, 2108 Nicholasville Road, Lexington, Kentucky 40503. Orders may be sent to the FCMS with a check for $60 per book.

PEOPLE

Dr Robert Wood, Associate Director of Trover Clinic Foundation's Family Practice Residency Program, recently received notification that a presentation made by a group of individuals from Trover Clinic Foundation's Family Practice Residency Program and Regional Medical Center has been selected for inclusion in the Program for the 1990 Society of Teachers of Family Medicine Annual Spring Conference.

The presentation, entitled "Medical Ethics: Preparing Residents For The Inevitable," addresses the decisions that physicians must make in dealing with the dying patient. It discusses how the resident can approach the family in bringing up medical issues as well as the physician's role in decision making. The topic emphasizes the team effort required during this time.

Team members and presenters include **LaMont Wood, MD,** Associate Director, and **Robert B. Cloar, MD,** Director, of Trover Clinic Foundation's Family Practice Residency

Program; **Ford Threlkeld, MD,** second year Resident in the Program; Donna Montgomery, LSW, Director of Social Services at Regional Medical Center; and Bill McCann, MDiv, a Chaplain at Regional Medical Center.

This presentation was chosen the best of the Southeast region and will be presented at the National Society of Teachers of Family Medicine meeting to be held in Seattle, WA in May 1990, and at the Annual Directors of Family Practice Residency Programs Meeting in Kansas City in June 1990.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Fayette

James A. Gibson, MD — P
1134 Arbor View Ct, Lexington 40517
1954, Harvard Med School

Jefferson

Mark Robert Behr, MD — ANES
867 Mallard Creek, Louisville 40207
1985, U of Louisville

Vasti Broadstone, MD — IM
530 S Jackson, Louisville 40202
1976, U of Rio de Janeiro

Mary Lynn Bundy, MD — PD
1726 State St, Jeffersonville IN 47150
1986, U of Louisville

Jahangir Cyrus, MD — IM
530 S Jackson, Louisville 40202
1969, U of Tehran

Matthew J. Fargen, MD — IM
232 Medical Towers, Louisville 40202
1986, U of Louisville

Sarah Jean Fitch, MD — PD
PO Box 35070, Louisville 40232
1978, U of Mississippi

Eugene Giles, Sr, MD — IM
250 E Liberty, Louisville 40202
1981, Meharry Med College

Gregory Hudson, MD — PD
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1986, U of Kentucky

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1985, Wayne State U

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1980, Indiana U

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1984, U of Illinois

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1980, St Louis U

McCracken

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1985, U of Cincinnati

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1986, U of Cincinnati

Carol S. Moore, MD — PD
20 Medical Village, 102, Edgewood 41017
1986, Med College of Alabama

Simpson

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1968, Royal Coll of Surgeons, Ireland

Warren

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280 April Way, Bowling Green 42101
1983, U of Kentucky

Lawrence Michael Litt, MD — IM
1300 Ashley Circle, Bowling Green 42104
1973, Temple U School of Medicine

Whitley

Abdolazim Vaezy-Anzoha, MD — PUD
Corbin Medical Associates, Corbin 40701
1969, U of Tehran

New In-Training

St. Elizabeth —
Thomas K. McCormick, MD — **FP**

UK —
Timothy E. Dineen, MD — **R**
Stephen Kent Hall, MD — **OBG**

UL —
James William Bosler, III, MD — **IM**
Mark A. Brockman, MD — **PD**
Travis N. Calhoun, MD — **IM**
Fred W. Caudill, MD — **P**
Robert Lee Caudill, MD — **P**
Robert Craig DeWeese, MD — **SU**
Rachael Lynn Dotson, MD — **IM**
Elizabeth Marie Exparza, MD — **FP**
Helen Y. How, MD — **OBG**
Therese Marie Keeling, MD — **P**
Kathryn R. Marshall, MD — **IM**
Allan Paris, Jr, DO — **R**
Thomas Eric Sehlinger, MD — **SU**
Richard Brian Sharp, MD — **PM**
Patricia A. Sinoway, MD — **IM**
Bennie C. Slucher, MD — **PD**
Suellen Elliott Stevens, MD — **P**

DEATHS

Edward J. Brockman, MD
Louisville
1921-1990

Edward J. Brockman, MD, a general practitioner, died February 18, 1990. A 1946 graduate of Indiana University School of Medicine, Doctor Brockman became an active member of KMA in 1952.

FORMATION OF KENTUCKY GERIATRICS SOCIETY

The Kentucky Geriatrics Society is in the process of finalizing its formal organization. The Society, which is initially sponsored by the KMA Committee on Care for the Elderly, is being developed as a scientific and educational group for individuals interested in geriatric medicine. The Society is currently completing requirements to apply for recognition as a distinct medical specialty group with the KMA, and has received provisional approval from the American Geriatrics Society for its efforts.

You are urged to join the group and lend your interest and support. Geriatric medicine is a rapidly developing field which will affect all areas of medical practice in the coming years, and your membership in the KGS is a step toward becoming involved in these new developments.

For more information or a membership application, please contact the KMA Headquarters Office or the Coordinator of the KGS Steering Committee, S. Philip Greiver, MD, Louisville.

Choosing a Health Plan

One of the problems with health insurance that physicians continually hear about from their patients is that patients aren't sure what types of coverages they should buy and many times find out after they have purchased a plan that it contains a number of exclusions or benefit limitations.

The Kentucky Medical Association has developed the following guide which we hope will aid individuals in their decision making process regarding health insurance.

Please feel free to remove this page and reproduce it as you feel appropriate. We hope you will find this information useful.

What You Should Ask About Your Health Insurance

- May I choose my physician?
- Is my current physician a member of the plan?
- Will my prescription be paid?
- Are x-rays covered by the plan?
- Are office visits covered? Shots (injections)?
- Can I freely choose to see a specialist or must I be referred by my primary physician?
- Does my primary physician control access to specialty consultation?
- May I choose my hospital?
- Will lab tests be paid?
- Will specialists' services be covered?
- Must I have certain surgical procedures done as an outpatient?
- Will I be screened by medical personnel other than a physician before I see my doctor?
- Do I have easy access to a physician on week nights and weekends?
- Will my health care plan cover me for cost of medical treatment at out-of-town facilities when I travel?
- Will dependents be covered if they reside out-of-state?
- Can I get medical advice from a physician over the telephone during nonoffice hours?
- Am I limited to a certain number of routine care appointments?
- Must I schedule my appointments for routine care far in advance?
- Are any illnesses excluded from the coverage?
- May I request a "second opinion" from an outside physician? If so, will I have to pay for it?
- Will I have to pay a deductible or partial payment?
- When and how often are premium rates subject to change?
- Can I be let go from the plan without advance warning or if I use it too much?
- Do I have to fill out claim forms or will my doctor/hospital do that?
- May I use local physicians and hospitals or must I use those approved by the plan, even if I have to go to another community?
- Is my physician required to obtain permission from the plan before services are rendered?
- Will I be covered for urgent care if it is not rendered in a hospital associated with my health care plan?
- What happens if my physician ceases to be a participant in the plan while I am under his/her care?

Basic Health Care Plans

Fee-for-service is the traditional manner of receiving and paying for medical care. You choose your physician, hospital, and any other medical care you need. You are charged for the care you receive. Often, your care is paid for through a health insurance company whose premiums may be paid by employers. You may pay a deductible (an amount you must pay before your insurance company begins paying for your health care), or a co-payment (you pay a portion of the bill and the insurance company pays the balance).

Health Maintenance Organization (HMO)

An HMO is an organization that provides health care to a group of persons for a pre-determined price. An HMO offers broad coverage at a fixed price. The prepaid fee stays the same for a given period of time, usually one year regardless of the amount of health care used. That fee may be paid by you or, in full or in part by an employer, government or some other sponsor. In some HMOs, services are offered only at specific locations by groups of physicians and other health care personnel. You are required to use the HMO facility and staff to receive medical care.

Independent Practice Association (IPA)

An IPA is a type of HMO. Physicians practice in their office and care for both IPA subscribers and other patients. IPAs are formed by physicians who enter into agreements, usually with an employer group or insurance company, to provide medical services to that group's employees. Since the IPA is an HMO, the patient still must choose a particular group of physicians and a specific medical facility from which to receive medical services.

Preferred Provider Organization (PPO)

A PPO is a group of health care providers who agree to provide services to a specific group of patients (usually employment based groups) at an agreed upon rate.

A Word of Caution

Keep in mind that there are many different types of HMOs, PPOs, IPAs, and other insurance plans being offered today. Each of them has specific restrictions as to the type of care you receive, where you receive it and from whom. Before joining any plan, or before changing your current medical plan, learn as much as possible about the options being offered to you. Ask for written information which outlines the pluses and minuses of each option and read it carefully. Before you make a final decision, discuss the options with your personal physician to make certain that you will be able to receive the care you need under the option you choose.

Finally. . .

You should realize that many employers choose a plan for their employees. You may not have a choice. However, the information and questions contained in this article will, at the very least, make you more aware of your current health care plan.

Your physician is the best person to help you understand what's happening in medicine today. If you have questions about any subject mentioned here, we encourage you to ask your physician.

KEMPAC Elects Officers for 1990

KEMPAC officers elected for 1990 are as follows:

David B. Stevens, MD	Chairman
Charles F. Allnutt, MD	Vice-Chairman
William P. VonderHaar, MD	Treasurer
Henry R. Bell, Jr, MD	Assistant Treasurer
Jerry Martin, MD	Secretary

The members of the KEMPAC Board of Directors are your representatives and encourage you to discuss political activity in your local area with them.

The districts and directors are:

First Congressional District
Henry R. Bell, MD — PO Box 517, Elkton, KY 42220
Larry Franks, MD — 216 Berger Road, Paducah, KY 42001

Second Congressional District
Salem George, MD — 1129 W Chandler, Lebanon, KY 40033
Jerry Martin, MD — 1167 31 W By-pass, Bowling Green, KY 42101

Third Congressional District
Wayne W. Kotcamp, MD — Ste 200, 601 S Floyd St, Louisville, KY 40202
William P. VonderHaar, MD — 1170 E Broadway, Ste 400, Louisville, KY 40204

Fourth Congressional District
Charles F. Allnutt, MD — 2660 Shaker Road, Lakeside Park, KY 41017
John S. Spratt, MD — 529 S Jackson, Louisville, KY 40202

Fifth Congressional District
James D. Crase, MD — 340 Bogle St, Somerset, KY 42501
Charles C. Moore, Jr, MD — 3603 W Cumberland Avenue, Middlesboro, KY 40965

Sixth Congressional District
John R. Allen, MD — 135 E Maxwell, #104, Lexington, KY 40508
David B. Stevens, MD — 1900 Richmond Road, Lexington, KY 40502

Seventh Congressional District
Samuel J. King, MD — PO Box 3207, Pikeville, KY 41501

Represent Auxiliary to KMA
Mrs Donald R. Neel (Faye) — 3 Stone Creek Park, Owensboro, KY 42303
Mrs Maurice J. Mueller (Kathy) — 78 Superior Avenue, Ft Mitchell, KY 41017
Mrs George Schafer (Pat) — 732 Greenridge Lane, Louisville, KY 40207
Mrs Thomas Slabaugh (Sugar) — 2160 Island Drive, Lexington, KY 40502

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Donald C. Barton, MD — Doctors' Park, Corbin, KY 40701
Wally O. Montgomery, MD — PO Box 7329, Paducah, KY 42001
Sam D. Weakley, MD — 220 Baptist East Office Park Bldg, Louisville, KY 40207

_____ YES, I wish to become a KEMPAC/AMPAC member.
_____ $100 Physician _____ $100 Spouse _____ $10 Resident _____ $10 Student
Personal check enclosed _____ Charge to my credit card _____ VISA _____ Master Card

_____
Credit Card No. Expiration Date

Signature _____

If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions are not limited to the suggested amount. Neither the AMA nor the KMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions.

A portion of voluntary political contributions will be used in connection with Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions are not tax deductible.

APPLICATION FOR SCIENTIFIC EXHIBITS

Kentucky Medical Association
1990 Annual Meeting

Commonwealth Convention Center, Louisville, KY
September 24-27

1. Title of exhibit _____

2. Name(s) of exhibitor(s) _____

   Address _____

   Professional title _____

3. Institution if other than exhibitor _____

4. Amount of backwall footage required _____

   (The draped booth has 4′ side walls. This footage should not be included in backwall footage required). TABLE DESIRED? _____

   (Table 2′ deep x width of backwall (footage) ELECTRICAL OUTLET DESIRED? _____

5. Will summary printed matter be available or obtainable for the interested physician? _____

6. Indicate sources of assistance provided to you in connection with this exhibit _____

7. Has this exhibit been displayed before? If so, when & where? _____

   _____

8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date _____ _____

Signature of Applicant

Fill Out and mail to:
RICHARD A. KIELAR, MD, Chairman
Scientific Exhibits Committee
Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing post-graduate education.

Applications for space should be received before June 1, 1990.

- **COMMERCIALISM, such as utilizing the name of sponsoring organization or facility, either on the exhibit or in printed materials, is PROHIBITED.**
- **KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.**
- **Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 3752 Crittenden Dr, Louisville, Kentucky 40209.**
- **Transportation and erection costs are the responsibility of the exhibitor.**
- **Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.**
- **Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.**
- **Exhibit must be dismantled and removed by 4:00 PM, Thursday, September 27, 1990.**
- **Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.**

Commonwealth Convention Center and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Commonwealth Convention Center for damages that may occur as a result of the exhibitor's use of the facility.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

MEDICAL AND OFFICE EQUIPMENT FOR SALE — Exam table; Burton lamp; UV light with timer; Dazor portable lamps; Midmark power table; Exam stools; Mayo stand; IV Pole; Trash receptacle; Slide trays; Portable oxygen unit; 8″ forceps with jars; 4 shelf storage cabinet; Ledger trays; 8″ needle holders. Contact the office of Dr Judith McGuinn, Owensboro, KY (502)684-5808. Ask for Nancy.

WESTERN KENTUCKY — Seeking physicians for evening and weekend coverage in a low volume emergency department. Attractive schedule and compensation. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc, 2240 S Airport Rd, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

EMERGENCY MEDICINE/KENTUCKY — Full/part-time Emergency Department positions for primary care physicians with ED experience and ACLS certification. Lucrative compensation and professional liability insurance procured on your behalf. Flexible hours, no overhead, choice locations. Contact: Ms Dianne Rabun at 800-777-1301. Coastal Emergency Services, Inc, Memphis, TN.

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Send C/V to:

Charles A. Webb, M.D.
Our Lady of Bellefonte Hospital
St. Christopher Drive
Ashland, Kentucky 41101

19-21 — The Virginia Society of Otolaryngology — HNS, Radisson Mark Plaza Hotel, Alexandria, VA. Guest speakers: Roy B. Sessions, MD; Charles Gross, MD. Contact: Donna Scott, 4205 Dover Road, Richmond, VA 23221; (804) 353-2721.

21 — Annual Oropharyngeal Cancer Symposium, "The Management of Post Treatment Problems in Head and Neck Cancer Patients," Health Sciences Center Auditorium, Louisville, KY. Co-sponsored by the American Cancer Society, Kentucky Division, the Kentucky Cancer Program, and the James Graham Brown Cancer Center. Contact: Pat Warring (502) 588-7870.

26 — Seminar on Caring for the Aging; sponsored by the Loyola University Mulcahy Outpatient Center, Embassy Suites Hotel, Schaumburg, IL. Contact: Staff Development, (708) 216-9253.

26-28 — Sixteenth Annual Postgraduate Course — High Risk Pregnancy Symposium; Hyatt Regency Hotel, Louisville, KY. Contact: Mr Gerald Swim, Continuing Medical Education Dept; University of Louisville; Louisville, KY 40292; (502) 588-5329.

27-28 — Sports Medicine for Physicians. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

MAY

9-12 — 39th Annual Scientific Assembly, Kentucky Academy of Family Physicians, Galt House, Louisville, KY. Contact: KAFP, 3323 Medical Arts Bldg, Louisville, KY 40217, (502) 451-0370.

11-12 — Low Back and Sciatic Pain: Evaluation and Treatment; Washington University Medical Center, St. Louis, Mo. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

16-19 — 13th Annual National Conference, "Rural Health! Empowered to Make a Difference," sponsored by The National Rural Health Association. Sheraton New Orleans Hotel, New Orleans, LA. Former U.S. Surgeon General C. Everett Koop, MD, will present the conference's keynote address. Contact: Robert Quick, Communications Director, National Rural Health Association, 301 East Armour Blvd, Suite 420, Kansas City, MO 64111; (816) 756-3140.

18-19 — "Lipids: Regulation, Reversibility and Therapy," Hyatt on Capitol Square, Columbus, Ohio. Sponsored by Ohio State University Division of Endocrinology and Metabolism. Contact: Ohio State's Center for CME, (800) 492-4445.

19 — Trauma Symposium. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

20-26 — Twenty-First Family Medicine Review — Session II. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

24-27 — "The Basal Forebrain: Anatomy to Function" — A conference to address why people forget; Hyatt Regency, Chicago, IL. Sponsored by the Neuroscience and Aging Institute at Loyola University Medical Center. Contact: Dr Napier, (708) 216-3261.

25-27 — Advances in Pediatrics. Marriott's Hilton Head Resort, Hilton Head Island, SC. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

25-27 — International Workshop on Californium-252 Neutron Therapy: Brachy and Boron Neutron Capture Therapy, Lexington Griffin Gate Marriott Hotel, Lexington, KY. Contact: Terry Stuart, Radiation Therapy Oncology Center, University of Kentucky Medical Center, Lexington, KY 40536-0084, (606) 257-4931.

JUNE

1-2 — 3rd Annual Contact Lens Course. Washington University Medical Center, St. Louis, MO. AMA Category 1 approved. Contact: Cathy Caruso, Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

4-8 — EVMS Family Medicine Review Course — Sixth Edition: Sheraton Beach Inn at Virginia Beach, Virginia. Sponsored by the Department of Family and Community Medicine of the Eastern Virginia Medical School. Contact: Office of Continuing Medical Education, EVMS, PO Box 1980, Norfolk, VA 23501-1980 or (804) 446-6140.

6-9 — Facial Rejuvenation. Ritz-Carlton St Louis Hotel, St Louis, MO. Sponsor: Washington University School of Medicine. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St Louis, MO 63110; (800) 325-9862, (314) 362-6893.

6-10 — 7th Annual Meeting of the Southern Orthopaedic Association. Hyatt Regency Hotel, Maui, Hawaii. Category I CME Credits TBA. Contact: Jeanette Stone, Southern Orthopaedic Association, 35 Lakeshore Drive, PO Box 190088, Birmingham, AL 35219-0088; (205) 945-1848.

VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema.* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function.* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema. Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia. Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium. Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy – Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers. Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema, rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema. Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings

Serum Electrolytes. Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen. In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit. Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests. Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension.* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure. VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia. In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486.

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For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

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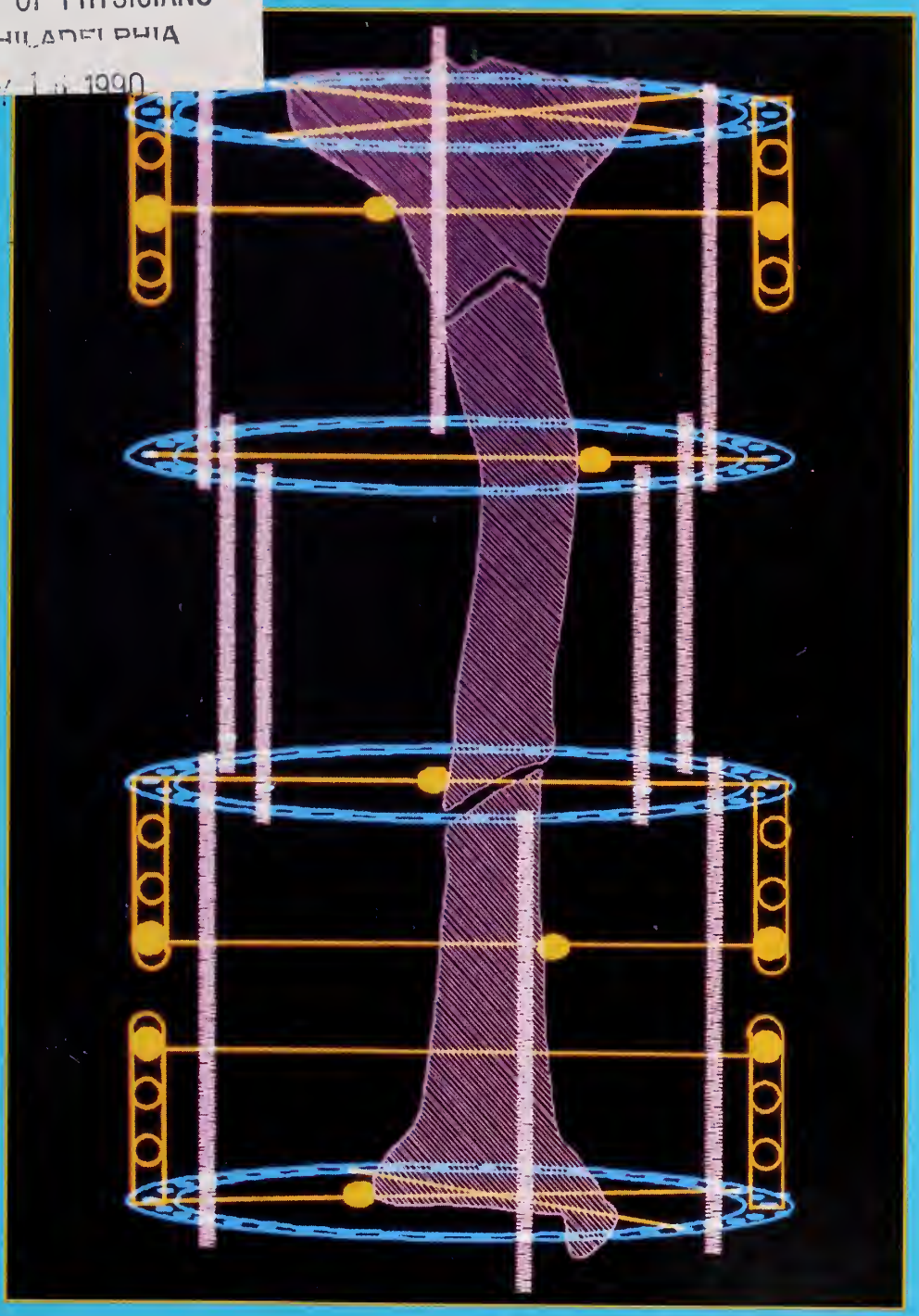

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References

1. *USP DI Update, September/October 1988, p 120.*
2. *Br J Clin Pharmacol 1985;20:710-713.*
3. *Data on file, Lilly Research Laboratories.*
4. *Scand J Gastroenterol 1987;22(suppl 136):61-70.*
5. *Am J Gastroenterol 1989;84:769-774.*

AXID®
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Brief Summary. Consult the package literature for complete information.

Indications and Usage: 1. *Active duodenal ulcer*—for up to eight weeks of treatment. Most patients heal within four weeks.

2. *Maintenance therapy*—for healed duodenal ulcer patients at a reduced dosage of 150 mg h.s. The consequences of therapy with Axid for longer than one year are not known.

Contraindication: Known hypersensitivity to the drug. Use with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy.

Drug Interactions—No interactions have been observed with theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450 enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increased serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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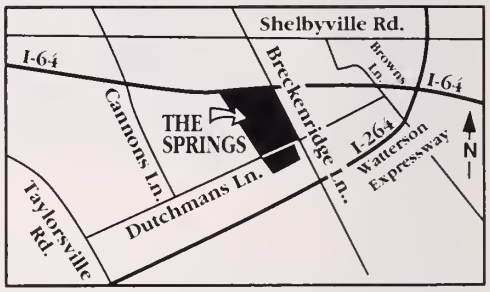

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Pride in Medicine

'In the 90s, we have the opportunity to improve the environment of medicine which will not only make us happy in the practice of medicine, but will encourage young people seeking a career choice to look at medicine as a profession in which they can take pride.'

The theme of the 1990 Annual Meeting of the Kentucky Medical Association will be "Pride in Medicine — A New Decade." As your President-Elect, I plan to use this theme throughout this year and my year as President. It is extremely important that we take pride in the accomplishments of our profession and that our patients benefit from all the profession has to offer today. Unfortunately, too often the positive aspects of medicine and the contribution of the individual physician go unnoticed or unappreciated because of the problems the medical profession is experiencing.

Escalating health care costs, the refusal of government to adequately fund the very programs they legislate, increasing numbers of people without access to health care, the cost of professional liability insurance, and the eroding positive image of the profession are just a few of the issues facing the profession. It is no wonder that some physicians are not content with their chosen profession.

A recent survey of physicians by the Gallup Organization found that 39% of those surveyed would definitely not or probably not go to medical school if they had it to do over. Only 24% said they definitely would go. This trend is reflected in the number of medical school applicants which decreased 25% over the past 5 years. However, we may now be seeing a reversal in this trend as medical school admissions have increased 5% nationwide. The number of applicants to Kentucky's two schools has risen slightly less than 5%.

At the recent AMA National Leadership Conference, Dr C. Everett Koop, former US Surgeon General, emphasized that the changing doctor-patient relationship was at the core of our problem. Dr Koop felt the relationship between doctors and patients took a turn for the worse when physicians allowed themselves to be called providers and patients became consumers. This placed a barrier between the doctor and patient. More and more we may see a "patient" as a potential suit or volume of paperwork.

In the 90s, we have the opportunity to improve the environment of medicine which will not only make us happy in the practice of medicine, but will encourage young people seeking a career choice to look at medicine as a profession in which they can take pride.

If we are going to achieve this, we will have to continue to work on the problems I have mentioned, but most of all, we need to point out the strong points of medicine . . . things we take pride in.

Much of the outcry for abandoning the US health system and adopting a nationalized approach such as those in Canada or Britain, has been the result of rising health costs and the lack of accessibility to health care for approximately 33 million people. The American Medical Association and organized medicine in general is addressing that issue. The AMA recently announced its "Health Access America" to deal with these problems. It is composed of a 16-step program

'We, as physicians, should take pride in what we've accomplished in medicine, what we are now doing in medicine, and the programs we propose for the future.'

which hopefully will not only be the solution to many of the difficult issues we face, but will indicate to the public that we are sensitive to their needs and are making every effort that we can to resolve their concerns.

I can say with pride that Kentucky has been a leader in addressing the access issue. Kentucky physicians have demonstrated their desire to help people regardless of their ability to pay. Kentucky Physicians Care, of which we are all aware, has been honored by the AMA as a model program in providing health care to those who otherwise might not have access. The Jefferson County Medical Society has recently assumed ownership and operation of the John H. Morgan Mission for Homeless Men. Both programs are the only medical society sponsored operations of their kind in the country. This year the Jefferson County Medical Society program was featured as a highlight of the AMA Leadership Conference, as was Kentucky Physicians Care last year.

'It is extremely important that we take pride in the accomplishments of our profession and that our patients benefit from all the profession has to offer today.'

We, as physicians, should take pride in what we've accomplished in medicine, what we are now doing in medicine, and the programs we propose for the future. By being strong patient advocates, patients will become strong physician advocates, and never before have we needed each other so much.

I would like to conclude by quoting from a poem entitled "Medicine is More Than a Profession," written by one of our members, Dr B.F. Andrews.

Medicine then is more than a profession.
Medicine is a worthy calling, a true avocation.
Medicine is a most magnificent obsession.
Medicine requires all the abilities in one's possession.
Its influence on life and death's progression makes Medicine more than a profession.

Preston P. Nunnelley, MD
KMA President-Elect

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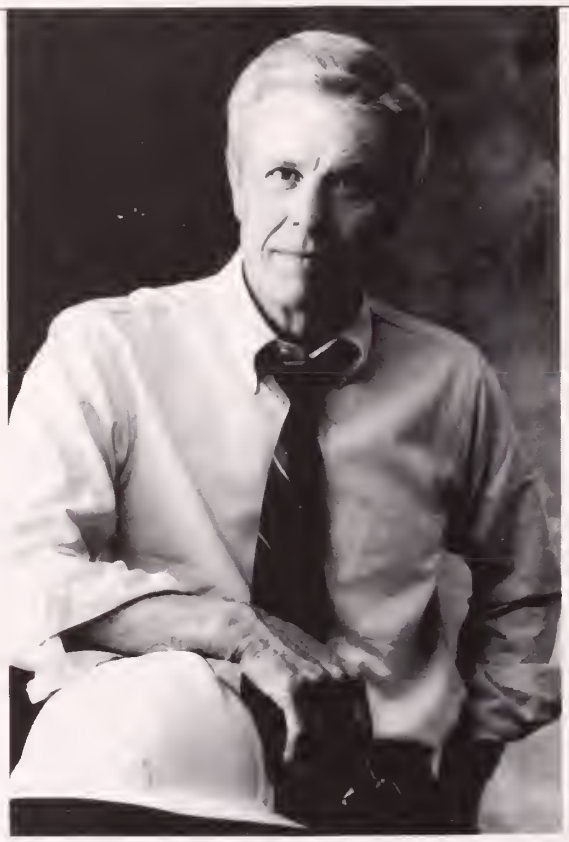

Losing Joe cost a lot more than money.

Joe has worked for me at the plant for nearly 15 years. Although the job can really be tough, he always gives his best.

But when Joe injured his back on the assembly line last year, I thought I had lost my most valuable employee. He was in so much pain, he couldn't work for months.

Then the company doctor suggested that Joe join the IndustryFit Program at Frazier Rehab Center. They had an outpatient center right in his neighborhood staffed with professionals specially trained to treat work-related injuries.

Joe started going to Frazier every day, slowly rebuilding his physical strength. The therapy team provided practical treatment tailored to meet his specific needs.

His therapists even visited the plant and suggested ways we could prevent further injuries.

Today, Joe is back on the job working harder than ever. That means a lot. Because losing people like Joe costs a lot more than money.

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AMA Delegate Report on Manpower

A report by Delegate Harold L. Bushey, MD

I have had the privilege of serving the KMA as Alternate Delegate and Delegate for the past six years. At the AMA meetings I was assigned to attend the reference committee that deals primarily with manpower.

An important issue that has been before us the last few years has been the AMA proposal for "Registered Care Technicians." The AMA had for at least 10 years tried to find means of increasing bedside care. Various mechanisms were tried and supported but had failed to provide the desired improvement, and the shortage of the bedside care givers was getting worse. The Board of Trustees had been instructed to come up with a plan of action that would get around the impasse. This plan envisioned a new category of care givers that would be a supplement to the current nurses, technicians, aides, and orderlies. The individuals in the program could progress along a proscribed plan of working and learning, in a stepwise manner within three levels of achievement.

When it was presented at the meeting in June 1988, there was considerable heated discussion by the delegates, AMA members, and invited guests of the nursing organizations. After many hours of debate, both in the reference committee and on the floor of the House of Delegates, a proposed trial was approved.

It has taken a year and a half to develop a curriculum and to find a suitable institution for a trial. At the meeting of the House of Delegates on December 3, 1989, the Board of Trustees presented an update, *Registered Care Technician Progress Report.* The basic idea of progressive steps in the learning process, coupled with bedside experience and instructions in a standardized curriculum has been adhered to. To quote from the report: "This curriculum is competency based for all three levels of preparation for the Care Attendant (CA), the Basic Registered Care Technician (RCT-b), and Advanced RCT (RCT-adv). This curriculum is intended to meet a need to identify core requirements to prepare health care workers to assist at the bedside under supervision." The competency-based curriculum for the two-month care attendant and the nine-month basic RCT has been completed. The advanced RCT curriculum is still in preparation. The program design seeks to avoid duplication of programs that are already available in the educational system. The curriculum includes applicable components of the military corpsman training, nursing assistants training, and basic first aid courses.

An important issue that has been before us the last few years has been the AMA proposal for "Registered Care Technicians." The AMA had for at least 10 years tried to find means of increasing bedside care.

Implementation of a pilot program has been slowed by the opposition. The AMA and the Parkway Medical Center in Louisville, KY have been negotiating to initiate the program at that institution. There has been significant opposition to this pilot program in Kentucky by organized nursing. However, the mood of the House of Delegates was to give the program a trial and see if it is viable.

The AMA has actively attempted to open dialogue in areas of disagreement, especially with the nursing groups, on both the national and the state levels. These efforts are being continued. One other resolution addressed suggestions to restructure nursing programs as an additional means to help alleviate the nursing shortage.

Physician recruitment and retention in rural areas is an ongoing problem that surfaced again this year. The emphasis was on gaining the interest of the students during their educational years, both in the medical school programs and the residency programs. Also legislation was requested for proper support of qualified training programs.

There has been significant opposition to this pilot program in Kentucky by organized nursing.

On the educational front there were several resolutions submitted to address both the undergraduate and graduate medical experiences. The

The movement toward a single examination for all physicians, including the FMGs, did receive mostly favorable comment.

aim was to improve the quality of education; but, to avoid excessive regulations in both the medical schools and hospital settings is like walking a tightrope and balancing the concerns of all parties.

Concern for safety of students and residents was discussed in some detail. The House asked for policies to be developed "on exposure to contaminated body fluids encompassing medical, legal, social, and financial responsibilities" [Resolution 18]. A report will be forthcoming on this matter.

Licensure examinations and licensing reports and resolutions were discussed extensively. The movement toward a single examination for all physicians, including the FMGs, did receive mostly favorable comment. However, use of the student's grades on the National Board Examination for purposes other than licensure was strongly opposed by the Medical Student Section. Also the structuring of the medical school curriculum specifically to pass the National Board Examinations was deplored.

The American Medical Association is continuing to work in the area of manpower. Hopefully there will be a cooperative spirit by all parties in the efforts to increase and improve bedside care. The Medicare and Medicaid programs have affected the demand and need for physicians. They are periodically changing the rules, requiring that physicians and the AMA remain continually on alert and ready to respond to these changes.

The Kentucky delegation is your voice at the American Medical Association. We welcome your comments and concerns, and need them to serve effectively at the national level.

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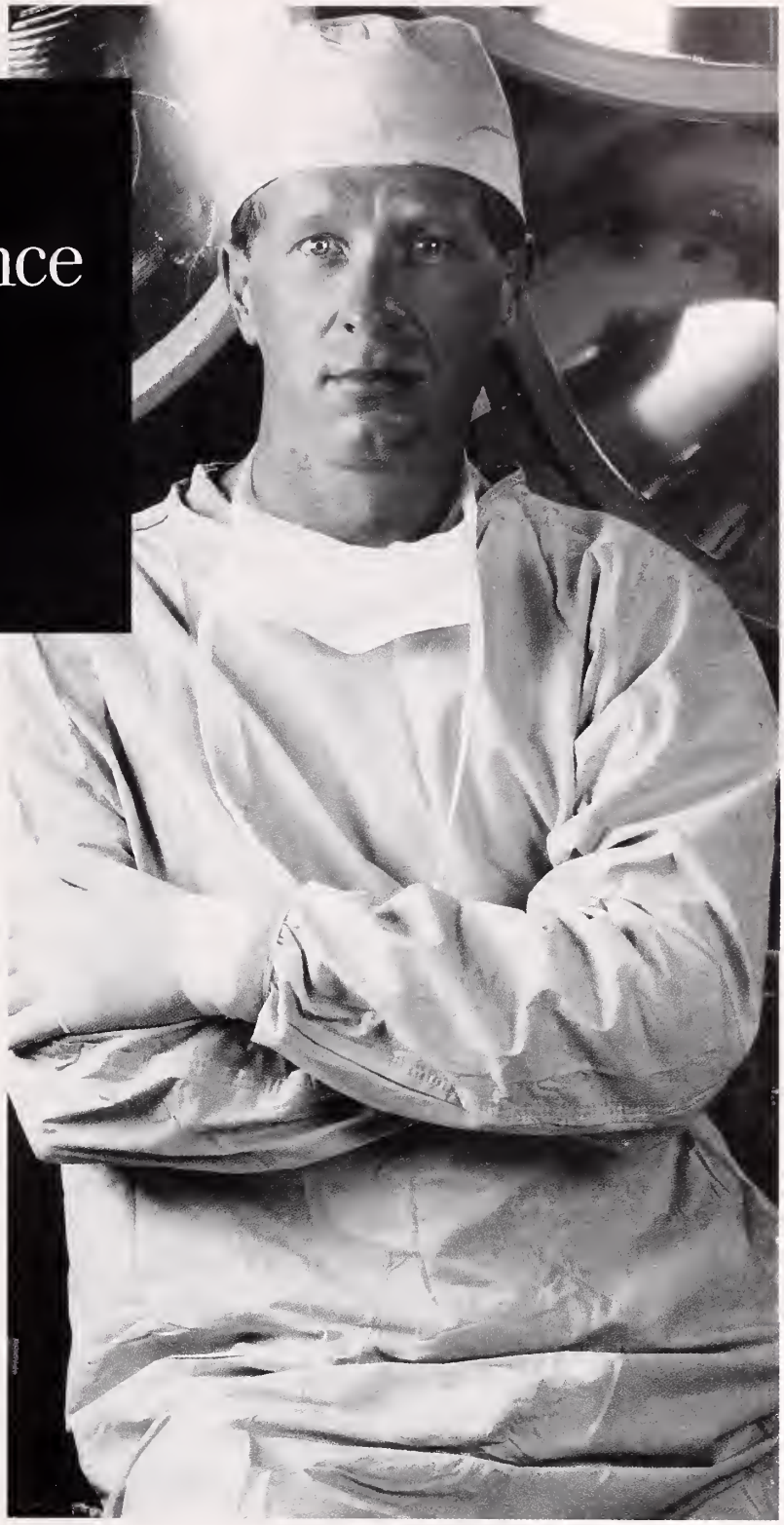

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A Preliminary Experience: The Ilizarov External Fixator

William R. Hoffman, BS; Stephen L. Henry, MD; David Seligson, MD

From the Department of Orthopedics, University of Louisville School of Medicine, Louisville, KY 40292.

The Ilizarov external fixator, though developed over 35 years ago in the Soviet Union, is only now gaining popularity in the United States. Its design and versatility allow the physician to treat a wider range of limb maladies than other external fixation systems (eg, the Hoffmann device). The Ilizarov method of fixation also permits treatment of some orthopedic conditions that were previously considered to be untreatable, such as dwarfism. The device can be used to correct limb length discrepancies, manage open and closed fractures, nonunions, and bony or soft tissue deformities. A review of the first 25 cases performed at the University of Louisville revealed 15 which have been successfully completed with significant, but manageable complications, and 10 cases which are still in progress.

Introduction

The Ilizarov external fixator was developed in 1951 by Dr Gavriel A. Ilizarov. Dr Ilizarov now heads the world's largest hospital dedicated to orthopedic medicine. It is known as the Kurgan All-Union Scientific Center for Restorative Traumatology and Orthopedics and is located in Kurgan, Siberia. It is estimated that the Ilizarov fixator has been used to treat one million patients in the Soviet Union since its development. Over 100,000 patients have been treated with the device in 60 countries outside the Soviet Union.[1] This includes the United States where it was first introduced in 1986.[2]

"External Fixation" is a comprehensive system for creating skeletal stability by means of metal fasteners placed in bone and linked together to make a frame.[3] The concept of external fixation arose during the latter half of the 19th century. The first external fixator was invented in 1894 by Dr Clayton Parkhill of Denver. External fixators were further developed and specialized enough that they underwent a clinical trial during the Second World War. After World War II, external fixators fell into disfavor in the United States because of associated complications. They did not resurface until the early 1970s with the development of better techniques and more scientific laboratory studies and clinical reviews. With the introduction of the Ilizarov fixator and similar devices, the topic of external fixation is now one of the most provocative topics in orthopedics.[4]

The Ilizarov apparatus consists of a small number of multi-purpose stainless steel components. It is a modular system with the main parts being rings, threaded and telescopic rods, and Kirschner (or "K") wires which are two millimeters in diameter or less. These "K" wires are passed through the limb and attached to the external rings under tension so that they act as if they were stiff fixation rods. Most cases involve a three or four-ring configuration. As presently available, the components can be assembled in over 600 different ways with each design custom-made for the particular orthopedic needs of the patient.[5]

Materials and Methods

Twenty-five consecutive cases involving Ilizarov fixators, which were applied at the Department of Orthopedics, University of Louisville between June 1988 and June 1989, were reviewed. The study involved a preoperative and postoperative evaluation of hospital charts, clinic charts, and radiographs. The data collected from this review is presented in Table I.

At the present time, 15 of these cases have completed their respective course of treatment and all have shown good results. The remaining 10 patients are currently undergoing outpatient treatment, clinic visitation, and physical therapy. The ages of the patients involved ranged from 5 to 56 with a mean age of 32. Twenty-one of the 25 cases involved the major surgical indications for the use of the Ilizarov. These are nonunion, bone fracture, limb deformity, and length discrepancy. The other four cases involved bone disease, tendon deformities, and malunion. The following are two representative cases of Ilizarov treatment.

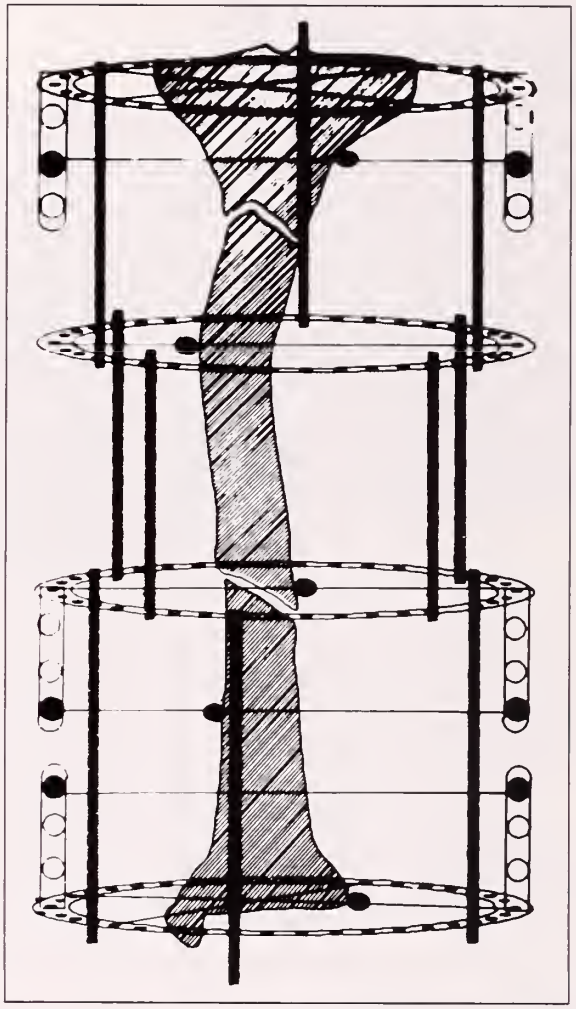

Fig 1A — Computerized representation of Case I showing Ilizarov fixator configuration. Drawn by Kurt Voos, University of Louisville, School of Medicine.

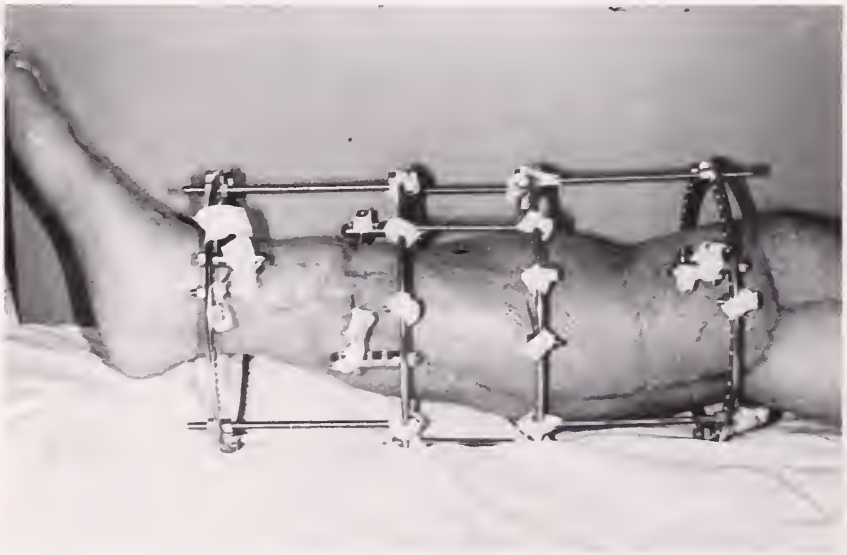

Fig 1B — Application of four ring fixator following latissimus dorsi flap coverage of a multi-level tibial fracture.

Case Reports

Case 1:

A 38-year-old male was admitted with a crush injury to the left tibia and fibula on June 30, 1988. The patient was involved in a job-related accident where a massive amount of steel fell on his leg. The patient was initially treated with irrigation and debridement of the wound and external fixation of the fracture with a Hoffmann external fixator. Antibiotic therapy, skin grafting, and microsurgery were also required and appeared to be sucessful. However, the patient subsequently experienced skin graft and pin site infection as complications.

The patient was readmitted at two months status post grade III open fracture with delayed union. At this time, no significant bony healing was observed and appreciable instability was noted. Thus, the patient was placed in an Ilizarov fixator with the ring configuration seen in Figs 1A and 1B. The course of treatment was unremarkable and no additional procedures were required other than removal of the fixator on April 17, 1989. The patient was placed in a full leg fiberglass cast immediately following fixator removal, which was eventually replaced with a leg brace. As of the most recent clinic visit, the patient showed good fracture site healing and was full weight bearing.

Case 2:

This 23-year-old male showed a congenital leg length discrepancy of unknown etiology. The lower left extremity was approximately 4 cm shorter than the right causing pain that centered at the knee joint. On May 17, 1989, a left tibial corticotomy was performed with placement of a four-ring Ilizarov fixator. The corticotomy was performed at the metaphyseal region of the proximal tibia and two rings were placed above and below this site (Fig 2). Initially, compression was applied across the fixator.

The patient was discharged 3 days after surgery with instructions concerning pin care, weight bearing ambulation, and manual lengthening of the system. The 4 cm distraction was completed as of July 13, 1989, with no complications (Fig 3). An additional 40 days of fixation were required for consolidation of the newly formed bone. As of the last clinic visit, the patient was doing well and x-rays indicated good alignment and union of the left tibia.

Table 1. Ilizarov Data Chart

CASE	AGE	INDICATION	BONE INVOLVED	#SURGERIES PRIOR TO APPLICATION	APPLICATION DATE	ADDITIONAL SURGERIES	REMOVAL DATE	COMPLICATIONS
01	21	Open fracture	Faat	3	6-7-88	0	9-8-88	Nane
02	19	Bane disease & bawing	Tibia	0	6-22-88	0	11-30-88	Nane
03	25	Nanunian	Tibia	12	8-9-88	4	1-9-88	Wire laasening
04	56	Nanunian	Humerus	0	8-24-88	0	11-1-89	Nane
05	38	Nanunian	Tibia	2	8-30-88	0	4-17-89	Nane
06	39	Campound fracture	Ankle	1	10-12-88	1	12-8-88	Painful washer required remaval
07	23	Nanunian	Tibia	2	10-17-88	0	12-13-88	Swelling
08	39	Angular defarmity	Tibia	3	12-5-88	0	1-23-89	Swelling
09	27	Supracandylar fracture	Femur	2	12-14-88	0	2-2-89	Excess Pain
10	24	Campaund fracture	Fem/Tib	3	12-19-88	0	2-18-89	Nane
11	26	Nanunian	Tibia	4	12-27-88	2	N/A	Wire breakage
12	24	Tendan Contracture	Ankle	9	1-11-89	1	3-9-89	Wire breakage; Swelling
13	39	Nanunion	Tibia	1	2-3-89	1	5-9-89	Wire laasening
14	33	Angular defarmity	Tibia	0	2-8-89	0	7-5-89	Nane
15	17	Angular defarmity	Tibia	0	3-9-89	0	5-17-89	Nane
16	42	Nanunian	Tibia	12	4-4-89	1	N/A	Wire tract infectian
17	26	Length discrepancy	Tibia	6	4-5-89	1	N/A	Nane
18	51	Angular defarmity	Tibia	1	4-11-89	0	7-12-89	Excess pain; Wire tract infectian
19	48	Nonunian	Humerus	3	4-24-89	0	N/A	Wire Infectian
20	25	Malunian	Tibia	0	4-26-89	0	N/A	Nane
21	23	Length discrepency	Tibia	0	5-17-89	0	N/A	Jaint cantracture
22	29	Nonunian	Tibia	12	5-17-89	1	N/A	Excess Pain; Wire loasening
23	36	Open fracture	Tibia	1	5-31-89	0	N/A	Nane
24	5	Angular defarmities	Ank/Knee	4	6-12-89	2	N/A	Wire breakage
25	54	Tendan rupture	Ankle	0	6-27-89	0	N/A	Wire tract infectian

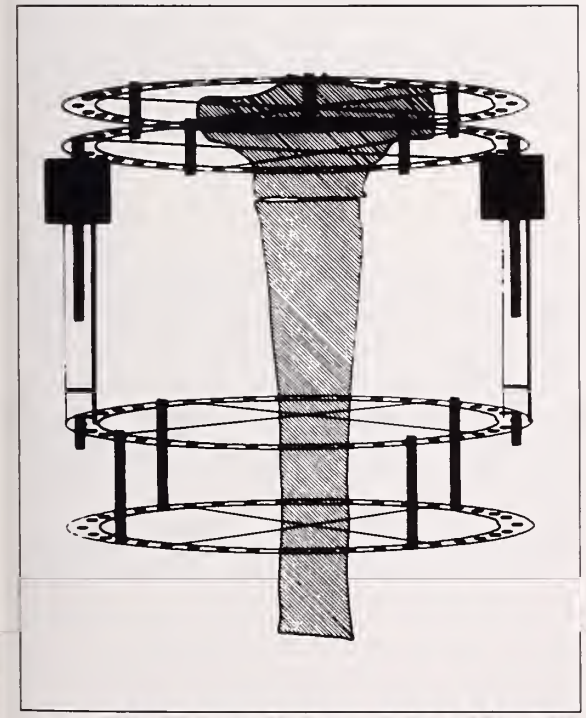

Fig 2 — Computerized representation of Case II at the time of frame application and corticotomy.

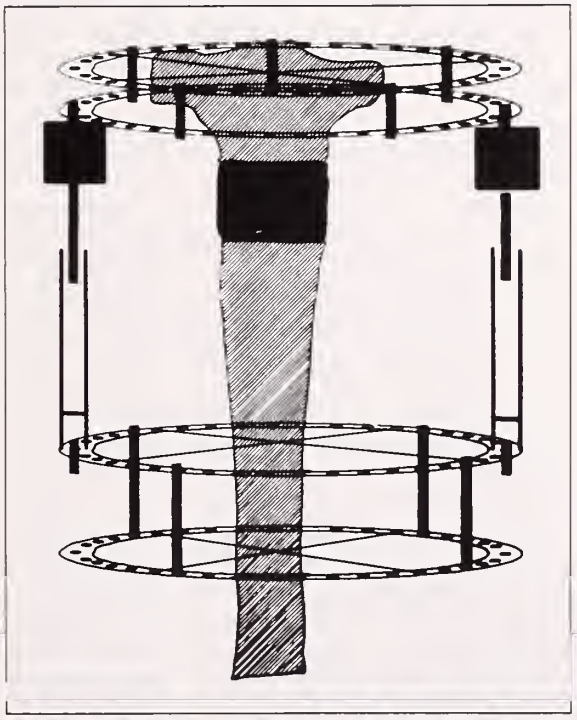

Fig 3 — Computerized representation of Case II after six weeks of growth process and distraction of 4 cm.

Discussion

Of the 25 cases reviewed, the most prevalent surgical indication observed was the nonunion. This is the failure of the process of bone repair to produce a firm union of fractured bone fragments. Unless this situation is changed by treatment, the nonunion will continue as a permanent and, in most cases, severely disabling condition.[6] Nonunion was noted as an indication in 9 of the 25 cases. Three of those cases had no complications, wire loosening was observed in 3, and wire tract infection was seen in 2 cases. Swelling, wire breakage, and excessive pain were all noted in the cases where nonunion was an indication. Although the greatest incidence of complication occurred with the nonunion cases, these cases were the result of trauma where the complications were minor compared to the severity of the injuries.

The Ilizarov is also used as a conventional fixation device for the treatment of fractures. Bone fracture was the indication in five of the cases reviewed. The fracture is first reduced and then the apparatus is placed on the extremity to maintain reduction. With the Ilizarov, one can treat the smallest limb segments or fragments and allow the patient to remain ambulatory.[1] Also, the Ilizarov holds bones in their anatomic alignment without the need for surgical exposure of the fracture site.[7] For these five cases, the only complications seen were excessive pain in one case and the removal of a residual washer in another.

Angular, or bony deformity was the indication in five of the cases reviewed. With the Ilizarov fixator, the physician can influence and control the natural growth process to correct deformities and repair damaged bone regardless of the problem.[1] It is interesting to note that the tibia was the bone involved in four of the five cases where angular deformity was the surgical indication. Two of the five cases showed no complications. However, wire breakage, swelling, pain, and pin tract infection were each observed once.

The most dramatic results of treatment with an Ilizarov fixator are seen in cases involving limb length discrepancy. This surgical indication was found in two of the cases studied. The Ilizarov method of bone lengthening hinges on the concept of "Distraction Histogenesis" developed by Dr Ilizarov. This concept is based on the premise that bone formation is stimulated by continuous distraction in the circular external fixator after a special osteotomy with minimal vascular trauma.[8] The lengthening process is broken down into three parts. First, the Ilizarov external fixator is attached to the effected limb with rings above and below the intended corticotomy site. Second, a corticotomy is performed so that only the bone cortex is cut and the bone marrow is undamaged. The last portion of the procedure involves the actual lengthening of the limb and is performed by the patient turning the distraction bolts four times a day. This is done at home and it permits bone growth of 1 mm per day with a maximum addition of approximately 50% of the normal length of the bone.[9]

Summary

After 38 years in existence, the Ilizarov external fixator is finally becoming popular in the United States. The exact nature of the delay in its use is unknown but it is probably due to a mixture of political and cultural differences as well as the geographical separation. The device is extremely versatile and can be used to treat bony defects, angular or rotational deformities, limb length discrepancies, closed or open fractures, and nonunions. With the increase in awareness of the device and further evaluation with clinical studies, the number of Ilizarov procedures performed in the United States should increase rapidly over the next few years.

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Exacerbation of Chronic Obstructive Pulmonary Disease Due to Hyperinfection with *Strongyloides stercoralis*

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Pulmonary infection due to the filariform larvae of Strongyloides stercoralis *may occur in immunocompromised patients residing in endemic areas of the United States. Such infection usually presents as dyspnea with a cough that sometimes results in bloody sputum. Although the chest roentgenogram often reveals a patchy bilateral alveolar infiltrate, acute respiratory distress is unusual. We report a patient who experienced severe exacerbation of his underlying obstructive lung disease that was associated with chest infiltrates and recovery of* S stercoralis *from his sputum. Although initial improvement was accomplished with Thiobendazole treatment, a reexacerbation occurred when antiparasitic therapy was completed. The persistence of his infection is correlated to factors that are commonly employed in the treatment of COPD but may be overlooked as predisposing causes of hyperinfection with* S stercoralis.

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Introduction

It is estimated that 4% of the population living in endemic areas of the southeastern United States become infected with the helminth *Strongyloides stercoralis*.[1] Although the respiratory system is integrally involved in the life cycle of *S stercoralis*, as many as 50% of patients remain free of any pulmonary symptoms during the initial acute infection.[2] The remaining patients usually suffer only transient and mild dyspnea and cough.

Under certain conditions, however, small numbers of rhabditiform larvae from the initial infection can revert to invasive filariform larvae which are capable of a more prolonged and severe clinical infestation resulting in hyperinfection or disseminated disease. The hyperinfection syndrome is characterized primarily by gastrointestinal complaints, but respiratory symptoms may occur and occasionally mimic pneumonia and/or airway obstruction, especially in immunocompromised patients.[3] The patient with chronic obstructive pulmonary disease may be considered immunocompromised from both his disease and its treatment. Increasing dyspnea, pulmonary infiltrates, and eosinophilia in patients with preexisting COPD who are being treated with corticosteriods should suggest the possibility of hyperinfection with Strongyloides. Those features of COPD and its treatment that may predispose patients to hyperinfection with *S stercoralis* are illustrated by the following case report.

Case Report

A 60-year-old man with a known history of chronic obstructive lung disease was admitted to the Louisville Veterans Administration Medical Center with nonproductive cough and acute exacerbation of dyspnea. He had been hospitalized on multiple occasions for exacerbations of COPD and had been treated successfully with aminophylline, beta agonists, and corticosteroids. At the time of admission his medications were cimetidine 400 mg twice a day, terbutaline 2.5 mg tablets 3 times a day, theophylline 300 mg 3 times a day, prednisone 15 mg each day, and inhaled metaproterenol 2 puffs 4 times a day. His medical history was also remarkable for a gradual 30 pound weight loss over the last 12 months. He had a past history of esophagitis and prepyloric ulcers. He had a 140 pack-year history of cigarette smoking.

The patient had spent his youth and most of his adult years in Kentucky.

His blood pressure was 110/70 mm Hg, pulse was 120/minute and regular, respiratory rate of 22/minute, and temperature was 38.6°C. Other remarkable physical findings included an increased anterior-posterior thoracic diameter, the presence of bibasilar rhonchi, and the use of the accessory muscles of respiration. The examination of his abdomen was remarkable for mild tenderness to

Fig 1 — Sputum smear demonstrating larva of **Strongyloides stercolaris.**

deep palpation. There was no rebound tenderness. He was awake and coherent. His neurologic examination was normal.

Laboratory findings on admission included hematocrit 30.5%; hemoglobin 9.9 gm%; and WBC count 17,000/mm3 with 80% neutrophils, 9% lymphocytes, 2% monocytes, and no eosinophils. Hemoccult positive stools were present. PPD and mumps skin tests were negative, suggesting anergy. The chest radiograph demonstrated changes consistent with bilateral basilar pneumonitis, which were not present on previous chest x-rays.

Initial treatment efforts were centered around exacerbation of COPD and included daily intravenous steroids, intravenous aminophylline, intravenous cimetidine, nebulized beta agonists, and controlled flow oxygen by Venturi mask at 40% FI02. Little improvement was seen in the patient's respiratory status with these interventions. Colonoscopy was performed because of melena and a decreasing hemoglobin. A biopsy from the cecal area, obtained during endoscopy, contained eosinophils and wormlike microorganisms. Two days later, stool specimens collected specifically for examination for ova and parasites were found to contain *S stercoralis*. Sputum collected after cough induction with heated hypertonic saline also contained *S stercoralis* (Fig 1).

Treatment was started with thiabendazole, 25 mg/kg twice daily for 2 weeks. The patient enjoyed subjective improvement in his respiratory status. After discontinuing thiabendazole, however, he began to become dyspneic again. Reexamination of several sputum samples confirmed that larval forms persisted. The patient was retreated with thiabendazole at the previous dose for an additional 3 weeks. This course of therapy resulted in symptomatic and radiographic improvement. Larval forms were successfully eradicated from the sputum and stool. The patient was observed in the hospital for an additional 2 weeks before being discharged with continued follow-up in the pulmonary clinic.

Discussion

S stercoralis is an intestinal nematode that is endemic to Kentucky and the southeastern United States.[1] The life cycle of this helminth is quite complex (Fig 2) with humans acting as the principal host. The nematode, however, has the ability to continue its life cycle in the soil. In the human, the female parasite resides in the intestine and deposits ova as it burrows into the intestinal mucosa. The parasite does not normally penetrate past the muscularis mucosa. The ova hatch into rhabditiform larvae within the mucosa and are then passed into the gut lumen and stool. The larvae develop into free living adults in the soil or form infective filariform larvae. Humans are infected when filariform larvae in the soil penetrate exposed skin, but can also be auto-infected if filariform larvae are retained in the gut and then subsequently penetrate the colonic mucosa. By either mechanism of entry, the infective filariform larvae access the blood stream, pass into the pulmonary microcirculation where they are mechanically trapped, cross into the alveolar space, ascend the tracheobronchial tree to the glottis, are swallowed and returned to the small intestine. The ability of this nematode to autoinfect gives it the potential to develop an ever increasing parasitic burden for the human body.[4,5]

In the vast majority of cases, *S stercoralis* infects and penetrates only the small bowel mucosa. In patients with an intact immune system,

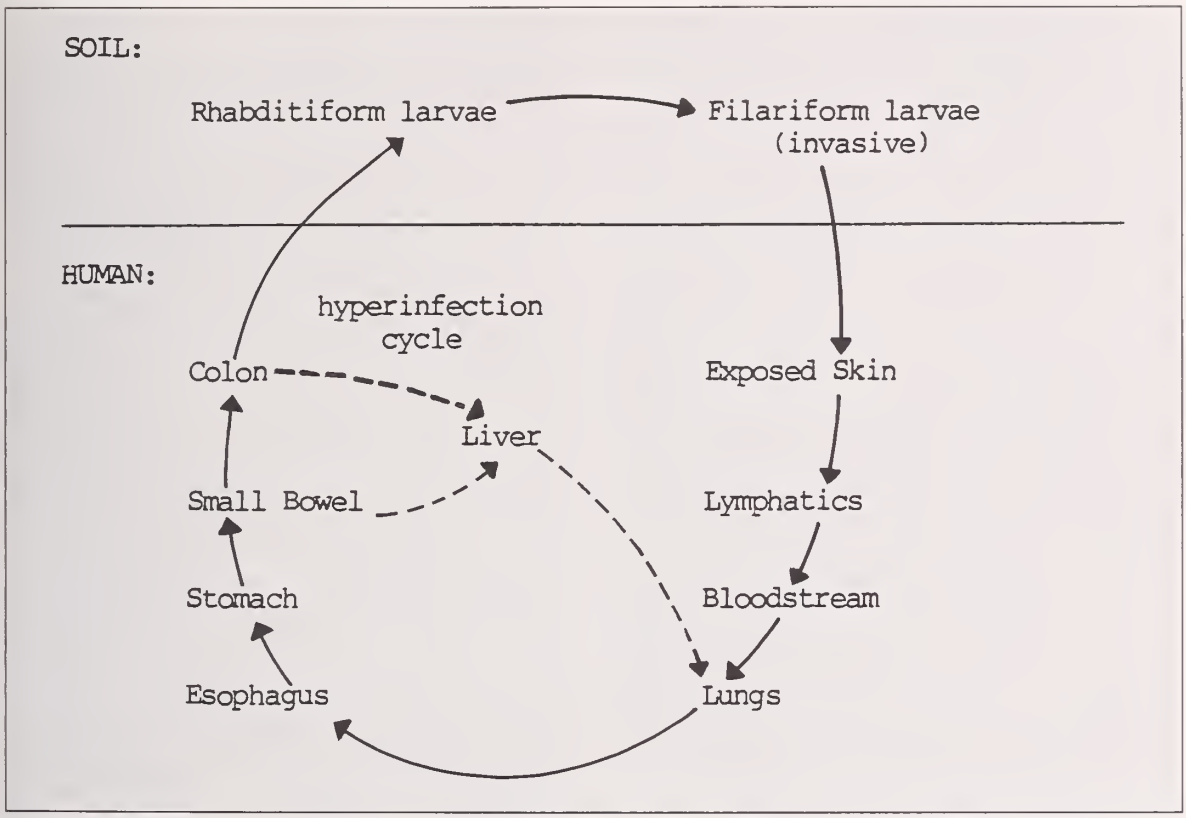

***Fig 2 — The life cycle of* Strongyloides stercoralis**

the organism can cause a "benign" infection, but can remain latent in the gastrointestinal tract for up to 25 years.[6] If the immune system is compromised, the acute infection may progress to a systemic dissemination or hyperinfection. Hyperinfection syndrome is the term used to describe an augmentation of the normal life cycle with larger numbers of the infective filariform larvae produced. Dissemination is the term applied when infective filariform larvae involve organs outside of the normal life cycle.

A number of risk factors have been identified for hyperinfection which occurs in approximately 1.5% to 2.5% of all infections.[1] Hematologic malignancies remain the major cause of impaired immune function in patients dying of Strongyloides hyperinfection. However, other significant risk factors include protein malnutrition, chronic alcoholism, and non-neoplastic systemic debilitating diseases such as severe COPD.[7] Cell mediated immunity appears to play the most important role in maintaining the host's defense against this parasite, while humoral B-lymphocyte derived antibodies appear to have only a minor role.[5,6]

In most reports, the need for gluccocorticoid therapy is the major recurring feature that places the patient at a disadvantage in handling an otherwise minor Strongyloides infection.[8] Approximately 15% to 30% of patients with COPD will show a significant improvement in airflow with the use of corticosteroids.[9] The risk is compounded by the observation that an estimated 50% of COPD patients who are hospitalized or participate in pulmonary rehabilitation programs are malnourished based on percent ideal body weight and anthropomorphic measurements.[10]

The H2 blockers, which are commonly prescribed when glucocorticoids are indicated in relieving airflow obstruction, have also been identified as predisposing agents for Strongyloides hyperinfection.[11] By decreasing gastric pH, these agents can allow colonization of the stomach by the parasite. They may also directly alter the immune response by suppressing T-lymphocyte function.[12]

The more impressive respiratory symptoms associated with hyperinfection such as asthma, bronchitis, pneumonia, and respiratory insufficiency occur if the larvae are not cleared and proceed to mature in the lung parenchyma instead of the gastrointestinal tract.[11] The pulmonary pathology is likely related to the large numbers of invading larvae. In the patient with severe COPD, impaired mucociliary clearance, ineffectual pulmonary toilet, or the use of antitussive agents may retard the elimination of the larvae from the lung.[13] Likewise, theophylline has been associated with gastroesophageal reflux and may slow the normal egress of the parasite to the small bowel. Bronchopneumonia may be a consequence of the direct parenchymal damage inflicted by the larvae or result from the sepsis that frequently occurs following larval transmission from the gut into the blood stream.[14]

The diagnosis of pulmonary Strongyloidiasis is made by careful examination of respiratory secretions. The time-honored and most cost-effective test is the Gram stain of sputum. The true sensitivity of the Gram stain for diagnosis of *S stercoralis* is unknown, but the specificity and ease of performance provide a logical starting point in the work-up.[15] Sputum containing *S stercoralis* has been obtained by transtracheal aspirate in patients without an effective cough. Fiberoptic bronchoscopy offers a more invasive but satisfactory method of isolating the parasite. Larvae have been recovered in bronchial brushings, aspirates, and biopsy.[16, 17] It has suggested that finding larvae in the sputum is sufficient to confirm a hyperinfection of organisms.[18]

Two cautionary notes deserve mention in the work-up of pulmonary Strongyloidiasis. Eosinophilia is often expected in parasitic infestation, but may be absent in corticosteroid treated patients. Secondly, Strongyloidiasis should not be discounted because of the absence of larvae in gastrointestinal samples. It should be stressed that multiple fresh stool specimens screened for ova and parasites will confirm the diagnosis in only 30% of patients. Duodenal aspiration with jejunal biopsy will yield the correct diagnosis in 90% of cases.[15]

When the diagnosis is secured, the infection is treated with thiabendazole, 25 mg/kg twice daily for at least 5 to 7 days. Thiabendazole is primarily excreted by the kidneys, and the dosage must be reduced when a patient also has renal failure. The use of this agent also has special precautions in the patient with COPD, since a theophylline-thiabendazole drug interaction has recently been identified.[19] A decrease in theophylline clearance of up to 50% has been observed, which resulted in theophylline toxicity at previous baseline doses. Theophylline clearance may not return to normal until 1 week after discontinuing thiabendazole. Close monitoring of serum theophylline concentrations is warranted in the COPD patient who requires both pharmaceutical agents.

The patient must be reevaluated with thorough sputum and stool examinations to insure that the infection is eradicated. If the organism is recovered, retreatment is indicated. The prognosis of Strongyloides hyperinfection is directly related to early diagnosis and treatment, especially in the noncompromised host. In one study of hyperinfection promptly treated with thiabendazole, all noncompromised patients survived, while only 59% of the immunocompromised hosts survived.[6] For individuals with stools positive for *S stercoralis* who undergo the standard thiabendazole therapy, a relapse rate of approximately 15% is expected. In patients such as ours who have a continued need for corticosteroids and H2-blockers, the relapse rate may be expected to be higher.[11] Infections resistant to thiabendazole have been reported to respond to pyrvinium pamoate and diethylcarbamazine.[15]

The two most common causes of death from pulmonary Strongyloidiasis are the bacterial sepsis that frequently occurs with invading larvae and massive intra-alveolar hemorrhage caused by the larvae's efforts to exit from the pulmonary capillaries into the alveoli.[14] ARDS has been reported as a complication of Strongyloides infection.[20] The mechanism of acute lung injury that results in noncardiogenic pulmonary edema is not known, but is postulated to be related to endotoxins associated with the gram negative bacteremia occurring with larval invasion of the blood stream from the colon.

In summary, *S stercoralis* is a parasite endemic to Kentucky and the southeastern United States which can result in infestation severe enough to cause pulmonary symptoms, including respiratory insufficiency and ARDS. Strongyloidiasis should be added to the lengthy differential diagnosis of cough, hemoptysis, wheezing, and interstitial infiltrates in the immunocompromised patient. Kentucky physicians are also reminded to maintain an increased index of suspicion for *S stercoralis* pulmonary infection in patients with exacerbation of COPD which is refractory or worsens with corticosteroid therapy.

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The History of Trauma: the University of Louisville Experience

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This article examines the history of trauma, the concept of a trauma center, and the trauma experience at the University of Louisville.

Every six seconds, someone in the United States dies as a result of trauma; every four seconds someone is injured, one permanently disabled.[1] Statistics such as these have created an increased awareness in the magnitude of trauma today, but the need for trauma centers has been around for decades.

The History of Trauma

The roots of modern trauma surgery may be traced back as far as the mid-1800s when Samuel D. Gross was named Professor of Surgery and later Chair of a newly founded Louisville Medical Institute (Fig 1). The Institute conducted classes in an amphitheater that was added onto the Louisville Marine Hospital. The hospital was a major center for the emergency treatment of river workers, persons who traveled along the Ohio River, and those who became ill or injured en route.[2]

Gross developed techniques while at the Institute for suturing intestinal wounds and published numerous books[2] on the treatment of traumatic injuries. Many of his trauma-related publications were viewed as state-of-the-art during that period. It was through his innovative and pioneering spirit that the University of Louisville became known as a leader in trauma surgery, but there were still milestones ahead as the tradition continued to grow well into the next century.

Around 1910, the old Marine Hospital was transformed into the new Louisville General Hospital, which was also the primary teaching facility for the University of Louisville School of Medicine. Within that decade, a designated accident service was developed there. To our knowledge, this represented the first designation in the country of a service whose primary mission was the care of patients with injuries and fractures.

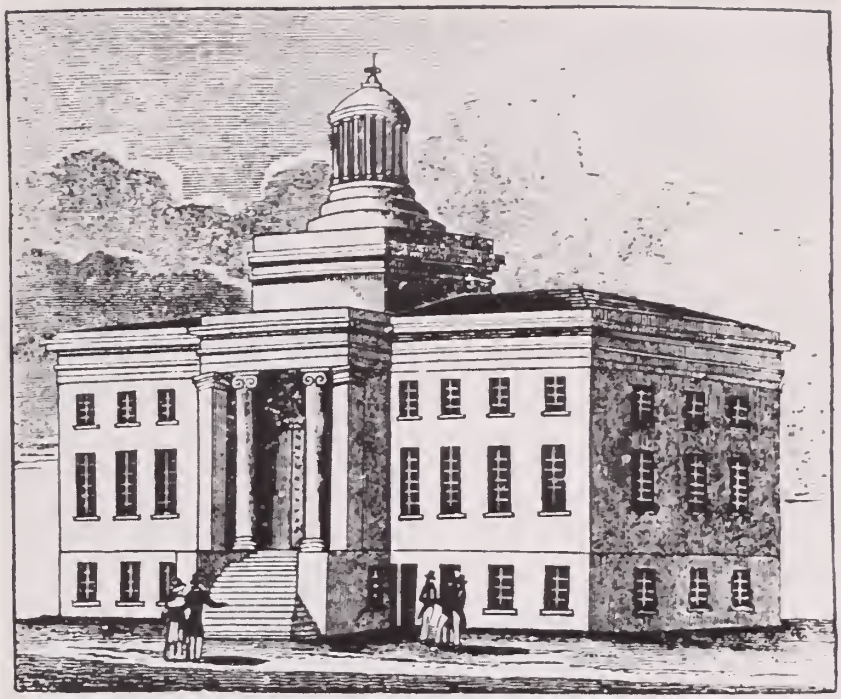
During the following two decades, the trauma service at Louisville General Hospital flourished under the leadership of University of Louisville's R. Arnold Griswold, ultimately Chair of Surgery, who had been interested in mechanisms of cardiac tamponade while working in Cleveland with Claude Beck.[3] By the late 1930s Griswold began a series of publications of cardiac wounds treated at Louisville General Hospital, and his results were unequalled by any center in the world.

In Griswold's numerous publications[4] on cardiac wounds, he emphasized several important principles. First, he developed a system of rapid transport to the hospital by using a police transportation system, which, in most cases, did not produce any unnecessary delays. Secondly, Griswold developed the concept of operating room rather than emergency department resuscitation, with the thought that the surgeon could quickly perform needed lifesaving operative procedures more expeditiously if resuscitation and evaluation were started in the operating room rather than in an emergency room. Thirdly, he stressed that first-line surgeons, who were primarily general surgery chief residents, should be able to repair wounds of the heart and not wait to have an attending surgeon present in order to initiate the operation. The delays in having attending surgeons present was unnecessary, Griswold thought, and would result in undue delay and increased mortality from heart wounds.

Dr Rudolph Noer followed Dr Griswold as Chief of Surgery at University of Louisville, and the unit furthered its interest in trauma surgery. Drs James Drye and Truman Mays made numerous contributions to the national trauma arena based on their work at Louisville General Hospital. The advent of Hiram C. Polk Jr, MD, to the Chair of the Department of Surgery in Louisville saw an even further strengthening of the trauma services at that institution. He recruited numerous

young surgeons interested in trauma care, including Drs Robert L. Fulton, Lewis M. Flint, J. David Richardson, and others too numerous to mention.

The primary contribution of the latter-day group of trauma surgeons was the development of specific trauma protocols to manage each of the major injuries that were likely to be encountered by the trauma surgery services. The development of such protocols was extremely important in resident training and in the preparation of the front-line surgical team for most eventualities that they might encounter. They also allowed for careful assessment of the proper ways to treat injuries since a large number of patients treated in a particular way could then be studied. Surgeons were thus able to readily assess the strengths and weaknesses of various treatment protocols, which would not have been possible if patients had been treated in a nonstandardized fashion.



By Courtesy E. F. Horine

Fig 1 — The first trauma surgery in Kentucky was performed in the Medical Institute of the City of Louisville.

Trauma Systems and Centers

On the national scene, trauma began to gain recognition as a specialty in 1961, with the opening of a two-bed shock/trauma unit at the University of Maryland. A first-of-a-kind grant from the National Research Council in 1963, solely for the study of trauma, spawned what is now a 101-bed trauma facility.[5] However, it was not until 1966 that national attention was given to the growing problem of trauma through the publication of the definitive study by the National Academy of Sciences on accidental death and disability.[6] This study forced scrutiny of the poorly organized health care delivery system for injured patients.

In March of 1966 the first "trauma center" opened at Cook County Hospital in Chicago. More importantly, this development gained the support of the federal government through funding for planning, improving, or expanding emergency medical services. A follow-up publication by the National Academy of Sciences[7] further documented deficiencies in trauma epidemiology, prevention, prehospital care, hospital care, and rehabilitation.

The growing movement for comprehensive trauma care was then augmented by the American College of Surgeons Committee on Trauma, who in 1976 appointed a special task force to further investigate the care of the injured patients. This task force advocated the categorization of facilities based on the institutional capacity to deal with a broad spectrum of emergency conditions. It was apparent from retrospective studies that a system designed specifically for trauma care would result in reduced morbidity and mortality due to trauma. In 1976, the Board of Regents of the American College of Surgeons approved this report[7] and authorized its publication as an official document. The criteria of classification for what we now call trauma centers was one result of this document.

An effective trauma system is comprised of four essential components: (1) access to care,

(2) prehospital care, (3) hospital care, and (4) rehabilitation. Each of these components work hand-in-hand to provide an integrated approach to trauma care and each addresses one primary objective, which is to return a functioning individual to society.

Trauma centers, which are vital components of a trauma system, may be categorized as either Level I, II, or III. These levels reflect the degree of commitment in caring for trauma patients, as well as the best possible use of community resources. Criteria for Level I and II centers, as set forth by the American College of surgeons' standards for trauma centers, require both levels to have in-house trauma surgeons, in-house anesthesiologists, 24-hour access to CT, angiography, operating rooms, 24-hour ancillary support, ability to provide trauma quality assurance, training programs, and trauma public education. In order to maintain an institution's expertise, it is estimated that 600 to 1,000 trauma patients are required per year for a Level I center and 350 to 600 for Level II.

The criteria for Levels I and II are virtually the same in regard to the quality of patient care. The main differentiating factor is research, which has historically been associated with teaching facilities. It was the intent of the American College of Surgeons Committee to make training and research in trauma an essential characteristic of the Level I hospital. Level III hospitals, generally located in smaller communities, provide a commitment to trauma that is commensurate with resources.

Categorization as a Level I, II, or III hospital is achieved by designation or verification. The designation process involves a formal legislative mandate either at the state or local level. Currently few regions have a specific mechanism for this process, although national legislation is pending. Verification is obtained through a site visit by an authoritative body, such as the American College of Surgeons, who carefully review the hospital's ability to meet the requirements for optimal care.

Recently, a trend has identified the overdevelopment of trauma centers, resulting in an excess number of hospitals providing suboptimal care for trauma victims and with poor utilization of resources. An effective trauma system requires a strategic analysis of the community and resources in an effort to avoid redundancy. Perhaps Freeark[8] phrased it best when he said that the decision as to which hospitals should be recognized as trauma centers would be resolved as soon as ego, pride, and avarice are brought face-to-face with economics, expertise, demonstrated commitment, and enlightened governmental influence.

Table 1. Triage Criteria for the Trauma Patient

Central Nervous System
- Head injury with penetrating injury
  - depressed skull fracture
    - open injury
    - cerebrospinal fluid leak
    - severe coma (GCS < 10)
    - deterioration in GCS or 2 or more
    - lateralizing signs
- Spinal cord injury

Chest
- Wide superior mediastinum
- Major chest wall injury
- Cardiac injury
- Patients who may require protracted ventilation

Pelvis
- Pelvic ring disruption/shock (> 5 units transfusion)
- Continued hemorrhage
- Compound (open) pelvic/pelvic visceral injury

Multiple System Injury

Secondary Deterioration (late sequelae)
- Patients requiring mechanical ventilation
- Sepsis
- Single or multiple system organ failure
- Osteomyelitis

Effectiveness — Trauma centers have proven their effectiveness in numerous reports. A well-known study that was conducted in California[9] compared the mortality of trauma patients taken to the closest hospital and those taken to an established trauma center. The results indicated that of those patients not taken to a trauma center, approximately two-thirds of the non-CNS-related deaths and one-third of the CNS-related deaths, were potentially preventable.[10] Other similar studies have estimated that the efficacy of a trauma system may result in a 30% reduction in mortality.[11]

It is important to recognize what constitutes a trauma patient. The guidelines promulgated by the American College of Surgeons provide a concise, sound basis for trauma patient identification and transfer (Table 1). The majority of trauma patients (90%-95%) do not require treatment at a Level I trauma center. However, the consequences of under triage can be devastating for patients whose injuries may initially appear minimal. Generally, the best rule to follow is to take the patient to a trauma center when in doubt.

Cost — The cost of providing the services required to maintain a fully functioning trauma system is a noteworthy issue, largely due to the fact that many trauma patients are unfunded. The burden of not being reimbursed is a significant consideration for most trauma centers, which again reinforces the need for public policy, community assessment, and strategic planning.

Perhaps more economically staggering is the cost of trauma to society. Fig 2 represents a breakdown analysis of the cost of trauma. As the figure demonstrates, medical expenses are only a small portion of the total cost of trauma care. Ideally, a trauma system that matches its community resources with the severely injured patient will maximize efficiency and minimize cost in terms of life, disability, and dollars.

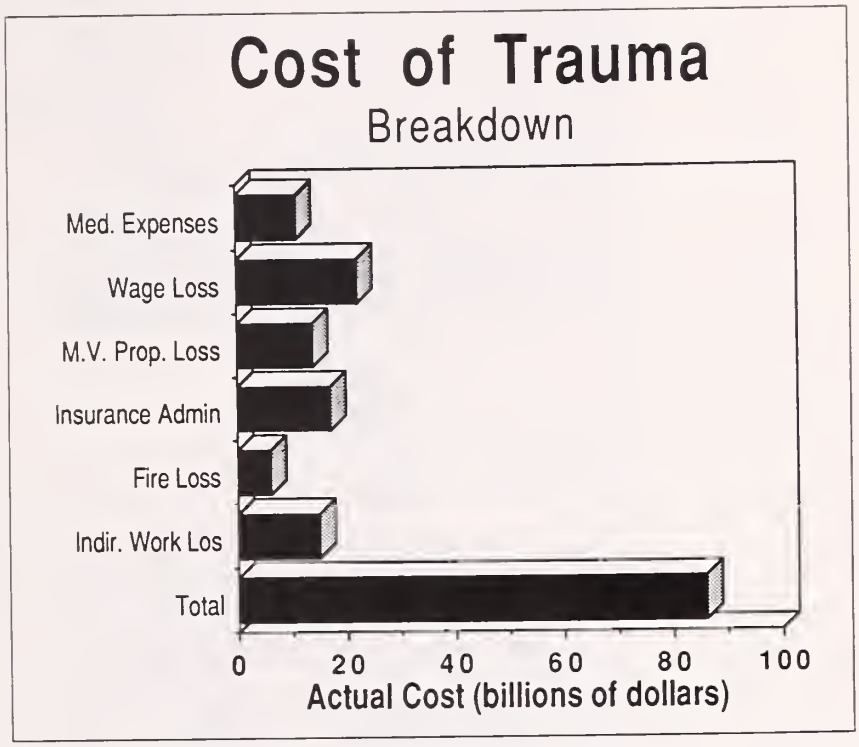


Fig 2 — Breakdown analysis of the cost of trauma (1982).

The University of Louisville Trauma Program

Our current trauma surgery service has two surgical teams led by a full-time faculty general surgeon. Each team consists of a chief resident, two junior residents, one or two interns, and one or two medical students. The teams alternate working days to provide continuous 24-hour in-house care. A multidisciplinary approach to the treatment of the trauma patient includes 24-hour availability of all other surgical services, laboratory, pharmacy, anesthesiology, and radiology, as well as access to CT scanning and emergency arteriography equipment. Fully staffed operating rooms and a blood bank are maintained 24 hours a day.

The emergency room serves as a vital adjunct in the initial management of these patients. In 1972, Dr Donald Thomas established the second emergency medicine residency program in the nation, although it was not until 1976 that emergency medicine gained recognition as a separate specialized department.

The development of an organized approach to trauma combined with the important support components play a significant role in the trauma center's ability to treat large numbers of patients. Fig 3 illustrates the type of trauma admissions to Humana Hospital University of Louisville for a one-year period from July 1, 1988, through June 30, 1989. A total of 1,553 patients were evaluated and treated by the Trauma Surgery Service for a total of 25,150 patient days.

Research — An additional commitment that the University has toward maintaining excellent care of the trauma patient involves ongoing research and education. Residents at all levels are encouraged to participate in research projects. The productivity of research conducted by the attending surgeons and residents is demonstrated by the annual output of scientific publications. Journal publications for the last 10 years average between 150 to 200 per year. In 1987 a definitive and widely read book on trauma was written and edited by our past and present faculty.[12] Each year, papers are presented at major surgical meetings throughout the country and abroad by both residents and faculty members.

Associated with the Department of Surgery is the Price Institute of Surgical Research. This Institute offers the surgical scientist an opportunity to conduct basic laboratory experiments and is a tremendous resource for undergraduate medical students, residents of the surgery program, and scientists from around the world. The focus of research in the Price Institute has been on both experimental and clinical studies related to the development of infection in the surgical patient, investigations of stimulation of nonspecific host defenses of the immune system, many aspects of multiple system organ failure, and the effects of

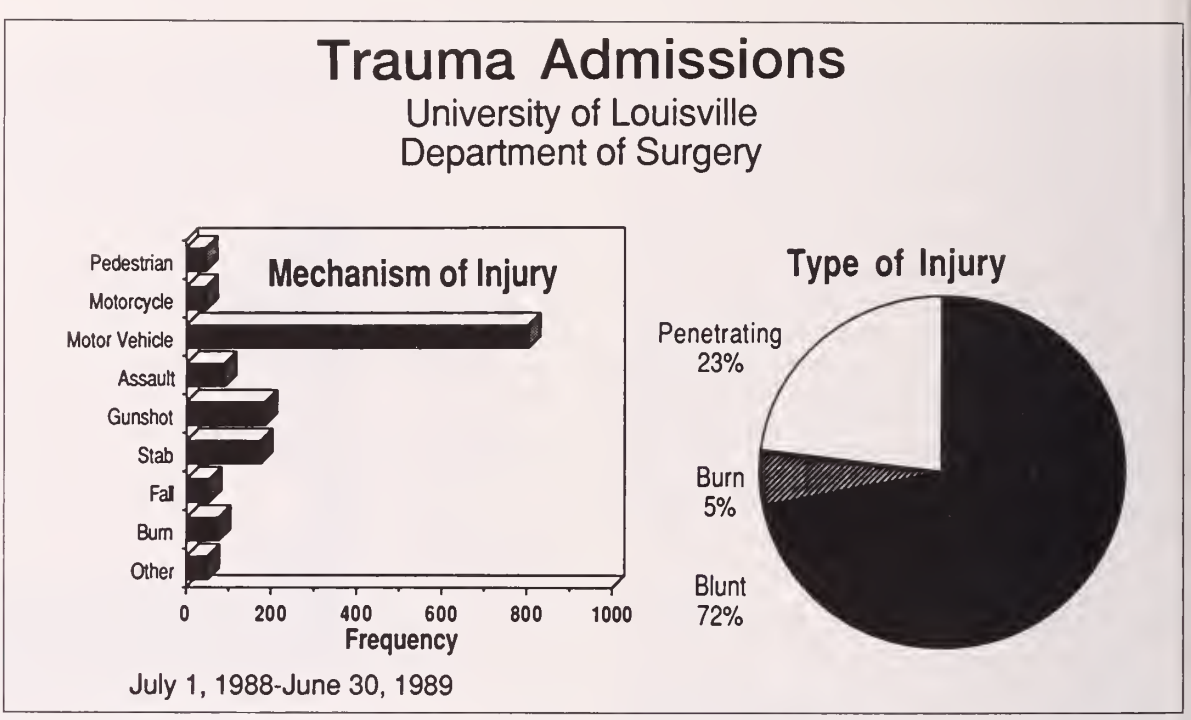


Fig 3 — Incidence of type of injury and mechanisms of injury for a 12-month period.

shock on various defense mechanisms and on the microvascular system.

The Price endowment provides for the appointment of a fellow in surgical research who is selected by the faculty from schools all over the world. In addition, there are two trauma fellows whose two-year program includes 12 months of basic laboratory research and 12 months of clinical responsibilities. Qualifications for trauma fellowship include successful completion of a five-year general surgery residency.

Humana Hospital — University of Louisville Trauma Grant

For more than 75 years, the University of Louisville trauma service has demonstrated its progressive commitment toward the care of the injured patient. On July 1, 1989, this commitment was reinforced through a generous grant from Humana, Inc, for the enhancement of the University's trauma program. More than $250,000 each year for a three-year period will be provided to broaden existing services and to intensify efforts that address trauma-related issues. This funding has led to the organization of a specialized staff of three trauma nurse coordinators who examine specific problems and implement programs related to the central theme of injury. An assessment of need regarding care of the trauma patient, research, and community awareness has been the impetus for the development of several programs.

In response to the need for ongoing education, the trauma program offers the Advanced Trauma Life Support (ATLS) course to physicians in outlying areas. The ATLS course, developed by the American College of Surgeons Committee on Trauma, provides the physician with a concise method of establishing assessment and management priorities in trauma care. Also, members of the surgery faculty, nursing staff, and emergency helicopter transportation personnel (STAT Flight) offer a wide variety of trauma-related in-service education programs. These are available to the practicing physician and community hospitals.

Tantamount to need for physician education is the need for follow-up information regarding trauma patients referrals. In an effort to facilitate increased communication, the trauma program provides referring physicians with vital patient outcome information. This information is also tracked through a computerized trauma database which serves as a quality assurance mechanism and a statistical resource in the area of trauma epidemiology and patient outcome. More importantly, the staff recognizes the communication

needs of the patient and family through support groups. These groups provide a unique opportunity for family members to voice concerns and ask questions in a nonthreatening, supportive environment.

Numerous studies have proven that most trauma is accidental and therefore preventable. The key to trauma prevention is the promotion of increased education and awareness among the community. Staff members of the trauma program have taken an active role in public education through a variety of community projects. The "Staying Alive" program, which addresses drinking, driving, and seat belt usage among teenagers, has reached over 2,000 high school students in the surrounding area.

The support of countless individuals has been instrumental in the development of a true trauma team approach. It is the ongoing refinement and improvement of these efforts that reflect the longstanding commitment that Humana Hospital University of Louisville has made toward improving trauma patient care.

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The AMA Hospital Medical Staff Section Fifteenth Assembly Meeting June 21-25, 1990 Chicago Marriott Hotel Chicago, Illinois

Highlights of the Annual Meeting will include:

- an educational program entitled, "Building Effective Hospital Physician Relationships: Ten Success Stories"; Stephen M. Shortell, Ph.D. will present the results of his study on the working relationships between ten selected hospitals and their medical staffs;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including the Impact of Hospital Bankruptcy, the Role of Hospital Governing Boards in Professional Review, and Information Sharing Among Medical Staffs;
- recommendation of policy to the House of Delegates on Prioritization of Health Care Expenditures and Notification of Denials by the PRO;
- AMA-HMSS Governing Council elections for the positions of Chairman, Vice-Chairman, Secretary, and one Member-at-large.

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
535 North Dearborn Street
Chicago, Illinois 60610
Phone (312) 645-4754 or 645-4761

HMSS

Learn Asthma Control in Seven Days

William Bailey, MD
Bryn Manzella, MPH

University of Alabama Hospital
Marketing Department
619 Sauth 19th Street
Birmingham, Alabama 35233

This guide evolved from several studies done at the University of Alabama on adult patients with asthma. Apparently the authors believe that this method is applicable to children as well. Seven chapters are really outlines for 7 days of work. Each asthma patient selects an "asthma control partner," with whom the daily lessons are studied and monitored. Even a contract is drawn to solidify this relationship. Educating the patient constantly in the form of pictures, tables, and text, the next chapter provides excellent layman information. Room for inserting the patient's particular medical history, including specific allergies, is allowed in the book. Resources such as physicians, hospitals, national organizations, etc, are documented and meant to be kept as the permanent record. Medications are discussed extensively, both in a universal sense and specifically to the patient being treated. Space for including the present schedule and diagrams for proper administration is given priority. Side effects are somewhat technically addressed, but appropriate to any medication discussion.

Finally, the dreaded asthma attack is dealt with extensively in the last two "days," or chapters. Prevention and treatment are comprehensively examined, to the point of defined drug intervention and avoidance of exacerbating factors.

A glossary of terms and even a certificate of "Congratulations to . . ." finishes this neat 86 page booklet. At $5.95 a copy — even less expensive in bulk order — this nice handout seems to fill a need.

Decade of Decision

The American Academy of Ophthalmology 1979-1989

William Campbell Felch, MD

The American Academy of
Ophthalmalogy Headquarters
655 Beach Street
San Francisca, CA

Evolution in medicine is no more sedate than in nature. For years ophthalmology and otolaryngology were mates, not really wed but certainly living together. Time and technological advances eroded this relationship, which had few solid connections except for relevant anatomy and some instrumentation. Independence was sought by both specialties, to facilitate professional interaction and to focus resources appropriately. In addition, governmental intervention was becoming both obvious and powerful. Economic whirlwinds caught medicine without marketing, advertising and management skills that could succeed in the environment of insurance and government medicine.

More a memoir than a historical tome, this paperback follows the personalities, the staff, the physical relocations and the practical considerations that occurred during this decade. For the non-ophthalmologist this information is both interesting and educational. The more the specialties become distinct, the more we need to remember that we have common bonds. Realities of the 1990s world abut on all of us and this collection of experiences may be relived by any group.

Photographs, lists, and an inclusive index make this small book a good reference.

Stephen Z. Smith, MD

This space contributed as a public service.

A Pessimistic Outlook

I recently discharged a patient from the hospital with a temperature of 100.2°F. The patient had been admitted with chronic obstructive pulmonary disease with an acute exacerbation requiring large doses of solumedrol. She also received ampicillin. Her course was one of gradual improvement over a 10 day period. On the day of discharge she felt well with clear lungs and was looking forward to going home. The cause of the fever was unexplained. However, she looked so good that I felt it was in her best interest to discharge and follow her at home.

Five years ago, I would not have given the above scenario a second thought. In today's climate of delayed second-guessing by the Medicare overseers, I was aware that this sort of decision would be questioned and I could be penalized, particularly if anything went wrong.

'. . . We are all forced to increasingly practice defensive medicine. And unfortunately for our patients, defensive medicine is usually bad medicine and not in the patient's best interest.'

I spent a miserable day worrying about the discharge. Finally, I realized all I can do is practice the best medicine I know how and forget the possibilities of sanction and censure.

The patient became afebrile that afternoon but the next day developed a rash most consistent with a drug eruption secondary to ampicillin. She has done well since. The fever was probably a manifestation of the impending drug eruption.

The point of the story is that we are all forced to increasingly practice defensive medicine. And unfortunately for our patients, defensive medicine is usually bad medicine and not in the patient's best interest.

I have no solution. I despair of the government forces ever admitting or realizing how they are impacting the practice of medicine in such a negative sense. A unified position by doctors on anything is a near impossibility. And so, like the buffalo who fails to flee from his attacker, I am afraid we will be forced from the field one by one — alone, misunderstood, never quite realizing what happened.

Paul C. Grider, Jr, MD

SIDEWALK SALE.

Each year, millions of dollars of legally prescribed drugs are diverted for illegal purposes. And some of America's best doctors are the unknowing sources, tricked by scams so sophisticated they deceive even the most vigilant physicians.

But the AMA is working to stop this problem at the state level, with the Prescription Abuse Data Synthesis project or "PADS." Developed by the AMA, PADS helps states identify and curtail sources of prescription drug diversion and abuse and teaches agencies to organize their data with computer technology. So that suspicious patterns and irregularities in behavior can be recognized, analyzed, tracked and put to a halt.

The success of PADS has led the AMA to spearhead PADS II which will make an expanded and centralized computer data service available to interested states. Through these (and other) AMA programs, our members help stop prescription drug abuse *everywhere.*

Our members make a difference.

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JOIN TODAY.

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AMA AMERICAN MEDICAL ASSOCIATION

In most cases, medical association dues may be deductible as professional or business expenses.
Dues and other contributions to the AMA are not deductible as charitable contributions for Federal Income Tax purposes.

"Improve the Image of Medicine"

The following is the inaugural address given April 24 by Betty Schrodt, Louisville, as she assumed the presidency of the Auxiliary to the Kentucky Medical Association.

HONORED GUESTS, MEMBERS OF THE AUXILIARY —

First of all, let me thank you for the opportunity to serve this Auxiliary as your president.

As many of you know, it is customary for the president of this organization to create a theme. The theme for 1990-91 — the first year of a new decade — is "Improve the Image of Medicine." Let me develop this theme with you.

In the 1980s changes in the health care system in this country have increased at an amazing rate. We have seen continual involvement of the government and private business in the health care system. Correspondingly, the role of the physician in health care decisions has diminished. With these changes, the positive image of the physician as patient advocate has decreased.

If we think that changes in health care delivery have changed in the 80s — WAIT UNTIL THE 90s. At the last confluence in Chicago an official of the American Medical Association felt very definite that socialized medicine *of some form* would be in our United States within 5 years. Whatever changes do occur, it is imperative — IT IS ESSENTIAL — that physicians remain the primary advocate of the patient. It is our role as auxilians to promote this position through our programs and efforts.

In the past we have worked very hard in our counties promoting good relationships with the schools, hospitals, and patient care through our health projects. The Health Careers Fund is certainly a success with the many applicants which we receive each year, both through the state and county. It is my hope that someday every county can increase their Health Careers Fund, whereby more of the public will realize our good work. It is through these efforts that our image will change. The Legislation Committee has always been strong but we can work to make it stronger. Even though this will not be a legislative year in Frankfort, — Washington is always contemplating changing the health care system. Two additions on the board this year will be a liaison to KEMPAC along with a representative from Southern Medical Association Auxiliary. I feel that we need all the support and expertise available from these two organizations, along with the American Medical Association and American Medical Association Auxiliary, to do the job facing us in the 90s.

I would be negligent not to mention *that* all the committees of this auxiliary are extremely important. AMA-ERF raised again this year over $50,000 for medical education. Each and every committee has worked and will continue to work toward their goal — and working together we can accomplish our goals.

Our efforts are ever encouraging. For years the Ronald McDonald houses in Louisville and Lexington have reaped the fruits of our labors. With the start of the Covenant house in Jefferson County the people of the streets will reap the harvest of the medical community there.

We have begun with much success the challenge before us. If we can continue our work, and even improve upon the programs we have in progress, our contribution in the field of medicine will be rewarding.

'At the last confluence in Chicago an official of the American Medical Association felt very definite that socialized medicine of some form would be in our United States within 5 years. Whatever changes do occur, it is imperative — IT IS ESSENTIAL — that physicians remain the primary advocate of the patient.'

Once again I want to thank you for this high honor, and I know working together we will "Improve the Image of Medicine."

Betty Schrodt
AKMA President

The Hyatt Regency Hotel and Commonwealth Convention Center, site of the 1990 Annual Meeting, are located on Jefferson Street between 3rd and 4th Streets (see lower center of adjacent map). As indicated on the map, there is ample parking within a short distance of the hotel and convention center.

A NEW DECADE

• 1 9 9 0 •

Pride in Medicine

KMA ANNUAL MEETING • SEPTEMBER 24-27 • HYATT REGENCY-COMMONWEALTH CONVENTION CENTER • LOUISVILLE, KENTUCKY

This year's KMA Annual Meeting will be held in downtown Louisville at the Hyatt Regency Hotel and Commonwealth Convention Center. KMA is looking forward to hosting the meeting on September 24-27, at a location that offers ample meeting and exhibit space along with a variety of sightseeing, shopping, and dining facilities. Louisville is an ideal convention city and ranks among the country's top ten cities in convention attendance. At the same time it ranks the lowest in food and lodging costs.

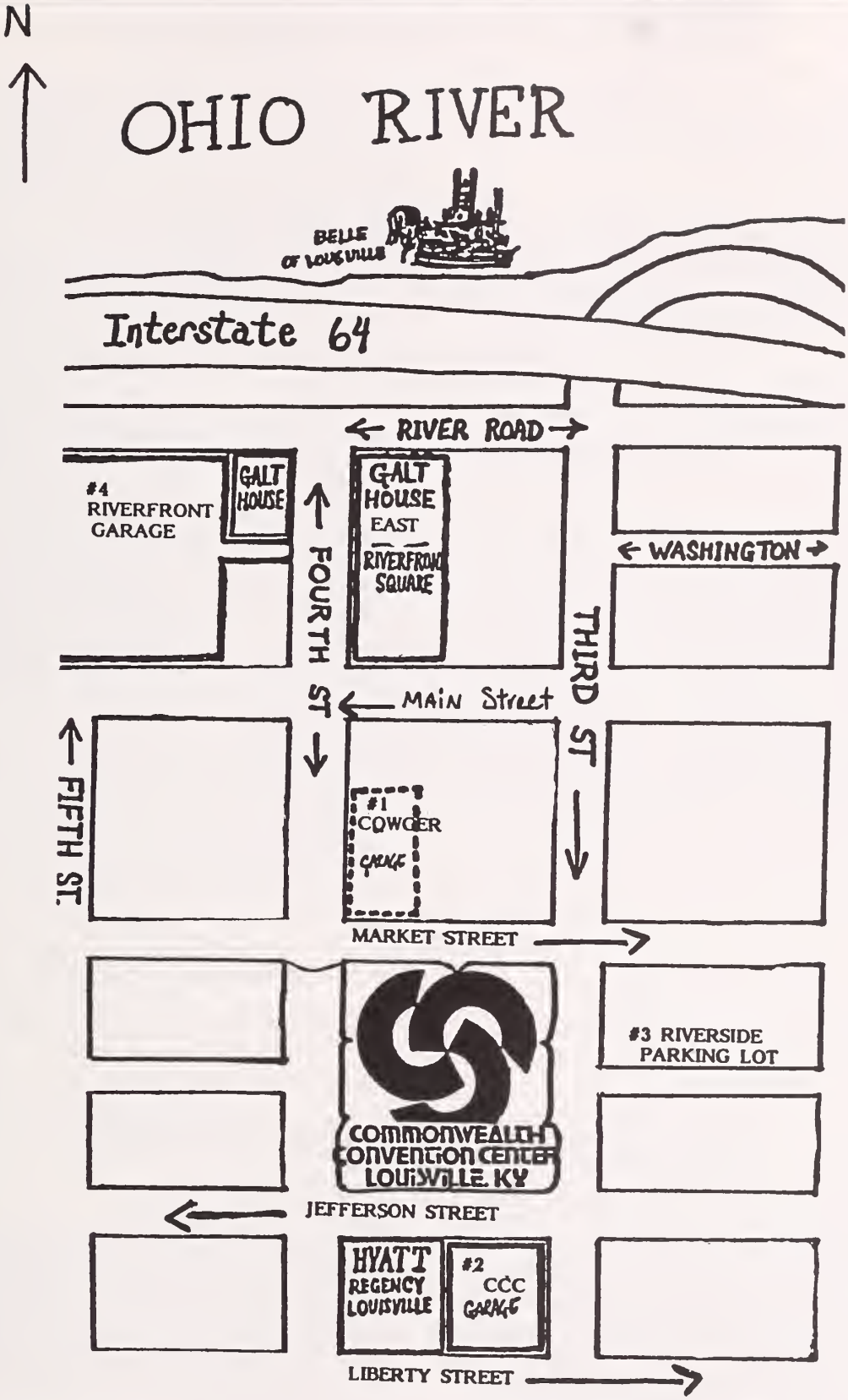
The March and April issues of the *Journal* contained information on the Convention Center, hotel, shopping, and sightseeing. This month our emphasis is on parking and transportation, and we are providing a map of the immediate area for your convenience in locating the hotel, convention center, and nearby parking facilities.

Parking and Transportation

Parking is hassle free in downtown Louisville. The hotel offers enclosed parking for 650 cars with additional parking available across the street and connected to the Convention Center by a walkway. There are ten additional CITYPARK garages conveniently located throughout the downtown area. Colorful CITYPARK banners on the garages will tell you where to park. For a fun and fast way to get around downtown, the Toonerville II Trolley is available **free of charge.** Each of the nine trolleys is a detailed reproduction of streetcars used during the turn of the century that feature mahogany seats and woodwork, along with gleaming brass hardware. The historic theme is carried out along the trolley route with authentically styled benches, planters and street lamps. Its 2.5 mile route links the Broadway area to the south end of the business district with the waterfront area at the north end.

If the weather gets bad, use the Skyways in downtown Louisville. These are easy indoor connections between hotels, parking garages, the Convention Center, the Galleria, and Starks Court.

kma



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#2 Commonwealth Convention Center (CCC) Garage
637 parking spaces
Managed by Commonwealth Convention Center

#3 Riverside Public Parking Lot
400 spaces
Managed by Riverside Parking

#4 Riverfront Garage
1,700 spaces after 5PM/300 before 5PM
Managed by APCOA, Inc

Nominations Being Accepted for Three Annual KMA Awards

Nominations are being accepted for three awards which are presented each year at the KMA Annual Meeting to outstanding physicians and lay people.

The *Distinguished Service Award* is presented each year to a physician in the state who has contributed to organized medicine or individual medical service, community health or civic betterment and medical research or distinguished voluntary military service. The nominee may qualify on any one or a combination of these points.

The *Kentucky Medical Association Award* is presented to an outstanding lay person in honor of his or her outstanding accomplishments in the field of public health and/or medical care. Recipients of the Distinguished Service Award and the Kentucky Medical Association Award will be chosen by the Awards Committee. **July 15** is the deadline for receiving nominations for these awards.

Nominees for the *Educational Achievement Award* are chosen from citizens of the Commonwealth of Kentucky who have made a significant contribution in medical or medically related education. Contributions in all areas of teaching, research, clinical application of medical practice and/or patient education are factors that will be considered. Recipients are chosen by the Continuing Medical Education Committee. **July 1** is the deadline for receiving nominations for the Educational Achievement Award.

Nominee material should include background and historical information about the nominee as well as justification for the nomination. ***kma***

KMA
Physician Placement Service

Physician placement is another service offered by the Kentucky Medical Association. The Association acts as a clearinghouse by providing assistance to physicians seeking practice opportunities in Kentucky and to anyone who is searching for a physician.

A booklet entitled "Practice Opportunities in Kentucky" is published in January and July. We combined our services with those offered by the Kentucky Physician Placement Service, Cabinet for Human Resources, Frankfort, Kentucky. As a result, there is a substantial increase in the number of opportunities listed. If you have just completed your medical training or are interested in a change of location, you will find this booklet helpful.

Kentucky Medical Association also publishes a "Physician Seeking" list which briefly outlines the background of the physician. This list is disseminated to communities, hospitals, clinics and physicians who are seeking the services of a physician.

If you are interested in these KMA services, please contact the:

PHYSICIAN PLACEMENT OFFICE
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205
Telephone: (502) 459-9790.

AWARDS NOMINATIONS

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

- Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
- Individual medical service
- Community health, education and civic betterment
- Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

AWARD NOMINATION FORM

Name: _____

Address: _____

Birth Date: _____ Place: _____

Marital Status: _____

Spouse's Name: _____

Children: _____

☐ Distinguished Service Award (Physician)

☐ KMA Award (Lay Person)

Education: _____

Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision.

Name of Person or Group Submitting Nomination: _____

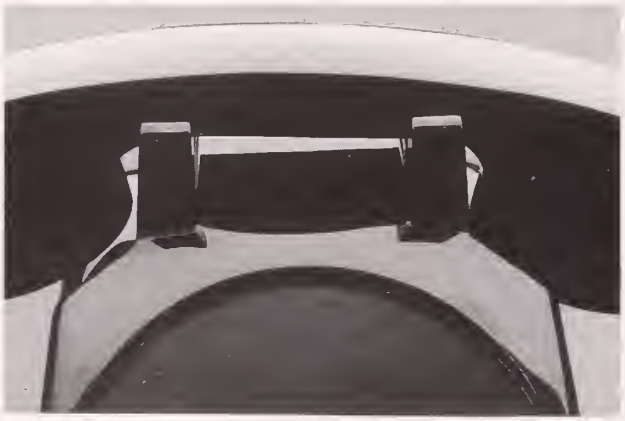
Address: _____

Phone: (Home) _____

(Office) _____

Please fill in and mail to: KMA, Attn: Awards Committee, 3532 Ephraim McDowell Dr, Louisville, KY 40205

Deadline for receiving nominations is July 15.



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Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it, however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
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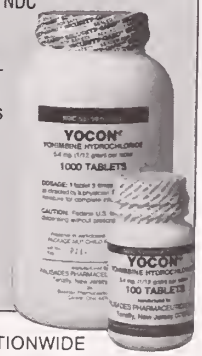
Rev. 1/85



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AMA Proposal — Health Access

The AMA is embarking upon an intensive campaign aimed at giving the medically vulnerable — the uninsured, underinsured, and the uninsurable — ready access to what other Americans already enjoy — the world's most advanced medical health system.

"Health Access America" is a formidable, 16-point proposal to restructure and strengthen the US health care system. Its primary goals are to reduce health care costs and ensure that all Americans, particularly the estimated 31 million uninsured, have access to health care. For your ready reference, listed is a brief outline of the 16-point proposal.

kma

16-Point AMA Proposal

- Medicaid Reform to provide adequate benefits to all below poverty level.
- Mandated employer coverage for full-time employees and families with tax incentives and state risk pools for new and small businesses.
- State risk pools for the medically uninsurable and others who cannot afford individual coverage and for whom group coverage is unavailable.
- Reform Medicare by creation of an actuarially sound, prefunded program to assure the aging population continued access to care. Funded through individual and employer tax contributions in working years.
- Expand long-term care financing through private sector coverage encouraged by tax incentives.
- Enact PLI reform to lower insurance cost and cost of defensive medicine.
- Develop MD directed practice parameters to assure appropriate care.
- Alter tax treatment of employee health care benefits to reward people for making economical health care insurance choices.
- Develop proposals that encourage cost-conscious decisions by patients.
- Seek innovation in insurance underwriting to develop larger, not smaller, pools to spread risk.
- Expand federal support for medical education and research.
- Encourage and promote healthy lifestyles.
- Amend ERISA or federal tax code so self-insured comply with state insurance regulations.
- Repeal or amend state-mandated benefit laws, but develop legislation for minimum benefits.
- Seek reductions in administrative costs.
- Encourage ethical practice by MDs and provision of voluntary care to those without insurance or who can't afford to pay for services.

PEOPLE

The Kentucky Chapter of the American College of Physicians has bestowed a new honor on one of KMA's retired members. **George William Pedigo, Jr, MD,** has been named the first Physician Laureate by this national organization for internists.

Dr Pedigo, 75, a former governor for the Kentucky chapter and former member of the organization's national board of regents, was presented with a medal at a ceremony in Lexington.

Former KMA President **Charles C. Smith, Jr, MD,** current governor of the Kentucky chapter, had these comments regarding Pedigo. "The universal thought was that this was the first person who should get the award in this state. He served as a role model for a whole generation of physicians who aspired to become internists."

Radiologist **James B. Douglas, MD,** who worked with him, commented on Dr Pedigo's deep concern for his patients. "There are so many doctors who are competent and well-trained but who are kind of cold potatoes. They don't really give patients a sense of warmth. He just personified that in a physician."

Dr Pedigo's dedication to excellence was evident throughout his career as a doctor, University of Louisville professor, consultant, and state medical leader. Even in his later years of practice he took, and encouraged others to take, a new national recertification exam.

A former president of the Jefferson County Medical Society, Dr Pedigo grew up in Glasgow. He was influenced to choose a career in medicine by his father, who was a veterinarian, and by **C. C. Howard, MD,** a highly respected Glasgow physician. He entered the University of Louisville School of Medicine and studied under internist **John Walker Moore, MD,** whom he said he idolized.

Dr Pedigo also has been honored with a lectureship named for him at the U of L Medical School. He still attends the weekly Medical Grand Rounds lectures, is a member of the board of overseers at U of L, and serves on a new Jefferson County Medical Society committee for retired physicians.

UPDATES

Transfusions Can Save Anemic Unborn

A blood transfusion can save a baby's life — even before the child is born.

University of Louisville obstetrician **Joseph Spinnato, II, MD,** is performing lifesaving blood transfusions in unborn babies. The procedure becomes necessary when a woman with Rh-negative red blood cells has a pregnancy in which the fetus inherits Rh-positive blood cells from the father.

Spinnato uses ultrasound to transfuse the fetus with cells that have been cross-matched with the mother's blood.

Research Laboratory Helps Take Load Off the Back

More than 80% of the US adult population suffers lower back pain. Doctors at the University of Louisville Spine and Spinal Cord Research Laboratory are looking for ways to cure and to prevent such problems.

The researchers are studying the stresses that cause the pain, as well as the forces placed on metal instruments used in spinal fusion operations, said neurosurgeon **Christopher Shields, MD.**

The researchers also are developing strategies to avoid or reverse the damaging effects of spinal cord injury.

Kentucky Program Provides Medical Eye Care for the Needy Elderly

Here's how you can help the elderly in Kentucky obtain medical eye care if they cannot afford it.

Tell them the American Academy of Ophthalmology reports they should call the toll-free Helpline of the National Eye Care Project:

1-800-222-EYES (1-800-222-3937)

Each qualified caller will be matched with a nearby Kentucky ophthalmologist. The physician has volunteered to provide medical eye care for disadvantaged elderly at no out-of-pocket cost to the patient. If the elderly person is covered by Medicare or other health insurance, the physician has agreed, for this project only, to accept insurance assignment as payment in full. If the patient has no medical insurance, the care is free.

To qualify the patient must be age 65 or older and a US citizen or legal resident. The patient must no longer have access to an ophthalmologist he or she has seen in the past.

This is not an eyeglasses program, and prescription drugs or hospital care are not provided.

Since it opened in 1986, the National Eye Care Project has received more than 2,952 calls from Kentucky residents, and has referred more than 1,944 needy elderly to volunteer ophthalmologists.

An enormous amount of potentially blinding eye disease has been detected and treated, both in Kentucky and nationwide by the program.

In Kentucky, the following number of cases of potentially blinding eye diseases have been detected and treated in 1,099 patients for whom records are available:

584 cataract
58 glaucoma
124 macular degeneration
24 diabetic retinopathy

"It is estimated that more than half of all blindness is preventable, and the elderly are particularly vulnerable to eye disease," said **Lowell L. Stokes, Jr, MD,** president of the Kentucky Academy of Eye Physicians and Surgeons. "We urge all disadvantaged elderly people who need medical eye care to call the toll-free Helpline for prompt assistance."

The National Eye Care Project is sponsored by the Kentucky Academy of Eye Physicians and Surgeons, and the Foundation of the American Academy of Ophthalmology, whose 17,000 members make up the world's largest organization of eye physicians and surgeons.

Neurosurgeons Mark Decade of the Brain

The Decade of the Brain, officially launched this year through a declaration from President George Bush as he signed Public Law 101-58, is hailed by the American Association of Neurological Surgeons (AANS) and the Congress of Neurological Surgeons (CNS) as an unprecedented opportunity for Americans to learn about preventing and treating diseases of and injuries to the brain, spinal cord and nerves.

The AANS and CNS plan to address specific disorders of the brain and spinal cord each year with a goal of covering the broad scope of neurosurgical research and treatment by the end of the decade.

These groups will hold a science and health writers, reporters and editors conference on June 19 that includes an overview of the function of the brain and spinal cord, a discussion of spinal cord injury and its effect on the individual's body and lifestyle; an overview of stroke with a review of its effect on people who are struck at various points in their lives from adolescents through the elderly; and a look to the year 2000 and its promise of hi-tech equipment in the neuroscience armamentarium. A series of displays and explanations of the kind of equipment for neurosurgical treatment that could only be hoped for not too many years ago, but is in use today, will be available for demonstration and discussion at the conference.

The American Association of Neurological Surgeons and the Congress of Neurological Surgeons together represent the approximately 4,500 US neurological surgeons. Their members are dedicated to excellence in education and in the practice of neurological surgery. Together the organizations sponsor the award-winning National Head and Spinal Cord Injury Prevention Program, whose message reaches 350,000 teenagers annually.

Journal Receives Compliments from the South

Managing Editor
Journal of the Kentucky Medical Association

Dear Sue,

I just received your February issue and wanted to tell you how much I like the cover art. The concept and artistic rendition are both exceptional. Who would have thought a cover on seat belts could be so arresting!

I really like the new design inside the magazine. It is clean and creative — very pleasing to the eye. You are certainly doing an excellent job with this publication.

Congratulations!

Best regards,
Susan J. Dillon
Managing Editor
Journal of the Medical Association of Georgia

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Fayette

James L. Borders, MD — IM
121 Sycamore, Lexington 40502
1979, University of Kentucky

Elizabeth J. Borrone, MD — PD
3150 Custer Dr, Lexington 40517
1959, University of Ottawa

John L. Caudill, MD — R
475 Denver Lane, Lexington 40503
1980, University of Kentucky

Terry D. Clark, MD — PATH
1740 S Limestone, Lexington 40503
1980, University of Michigan

Jefferson

Eleanor F. Asher, MD — ANES
953 Cherokee Road, Louisville 40204
1978, University of Louisville

Karen K. Bloom, MD — PM
595 Mallard Creek Rd, Louisville 40207
1985, Medical College of Pennsylvania

Karen C. Cummiskey, MD — OBG
601 S Floyd, #307, Louisville 40202
1981, University of Michigan

Peggy H. Fishman, MD — OPH
519 State Street, New Albany, IN 47150
1988, Medical College of Georgia

John P. Gott, MD — SU
601 S Floyd, #700, Louisville 40202
1981, University of Louisville

Keith Krawiec, MD — IM
4016 Gloucester Rd, Louisville 40207
1984, University of Louisville

Robb R. Shrader, MD — OPH
4001 Dutchmans, #6-E, Louisville 40207
1984, University of Louisville

Danny L. Stewart, MD — PD
11502 Redwood Way, Louisville 40223
1976, University of Louisville

Madison

Timothy H. Gregg, MD — ANES
8030 Elk Lick Falls, Lexington 40515
1978, University of Louisville

Northern Kentucky

Bruce A. Hamilton, MD — IM
226 Thomas More Pkwy, Crestview Hills 41017
1978, University of Cincinnati

Vo D. Nguyen, MD — NEP
20 Medical Village, #305, Edgewood 41017
1978, University of Liege

Pulaski

John A. Dickson, MD — H
103 Hardin Lane, Somerset 42501
1959, Queens University of Belfast

Rowan

Stephen B. Mitchell, MD — OBG
550 Crestview Ln, Morehead 40351
1985, University of North Carolina

New In-Training

St. Elizabeth —

David C. Coffey, MD — **FP**

UK —

Donna C. Burkhart, MD, — **PUD**

UL —

Phillip F. Bressoud, MD — **PATH**
William R. Davidson, MD — **PD**
Steven M. DeMunbrun, MD — **N**
Karla D. Guess, MD — **IM**
B. Todd Heniford, MD — **SU**
Michael J. Kelley, MD — **IM**
Todd M. Kirchhoff, MD — **OTO**
Cathleen J. Morris, MD — **IM**
Richard R. Morris, MD — **R**
Steve K. Overstreet, MD — **IM**
Randy D. Proffitt, MD — **SU**
Robert S. Redlich, MD — **R**
Zack R. Stearns, MD — **ORS**
Raymond R. Taylor, MD — **IM**
James M. Van Daalen, MD — **SU**
James A. Vansant, MD — **IM**

DEATHS

Edward W. Connelly, MD
Ashland
1917-1990

Edward W. Connelly, MD, an obstetrician-gynecologist, died January 22, 1990. Doctor Connelly was a 1942 graduate of Jefferson Medical College of Philadelphia and had been a member of KMA since 1952.

John C. Malek, MD
Lexington
1927-1990

John C. Malek, MD, a neurologist, died February 3, 1990. A 1955 graduate of State University of Iowa College of Medicine, Dr Malek had been an active member of KMA since 1963.

Nicholas J. Pisacano, MD
Lexington
1924-1990

Nicholas J. Pisacano, MD, a family practitioner and chairman of the board of UK's Albert B. Chandler Medical Center and UK professor of biological sciences, died March 11, 1990. Dr Pisacano was founding secretary and former executive director of the American Board of Family Practice for 20 years, and executive editor of the *Journal of the American Board of Family Practice*. He also served as director of continuing medical education at the university's College of Medicine from 1962 to 1968. A 1951 graduate of Hahnemann Medical College in Philadelphia, Dr Pisacano had been a member of KMA since 1963.

Robert J. Miller, DDS
Louisville
1910-1990

Robert J. Miller, DDS, a dentist, died March 22, 1990. Doctor Miller was a member and former vice president of the Louisville and Jefferson County Board of Health during the 1960s and 1970s, and was also acting dean of the University of Louisville dental school in the late 1970s. A 1934 graduate of the University of Louisville Dental School, he was a life member of KMA.

Willard J. Petway, MD
Paducah
1912-1990

Willard J. Petway, MD, an internist, died March 22, 1990. A 1944 graduate of the University of Louisville School of Medicine, Dr Petway had been a member of KMA since 1948.

Rural Kentucky Medical Scholarship Fund, Inc Establish Practice Grant Program

The Establish Practice Grant Program has met with great success. The program was initiated by the Rural Kentucky Medical Scholarship Fund Inc for the purpose of meeting the current medical needs of the people in critical counties. There are 24 counties classified as critical.

Upon completion of each year of practice, the physicians who participate receive $10,000 toward their educational debt for a maximum of four years for a total of $40,000 per physician.

Presently, Jerry Jamison, MD, is practicing in Russell County. Gary Partin, MD, is practicing in Adair County. Dennis Campbell, MD, is practicing in Knott County. Matthew Stiles, MD, upon completion of his residency training in June, will practice in Menifee County.

The RKMSF Board of Directors originally planned to offer only two grants a year, however, the program has been expanded to offer more than two grants annually, depending upon the availability of funds.

If anyone is interested in this worthwhile program, please contact the RKMSF Office, 3532 Ephraim McDowell Drive, Louisville 40205; telephone: 502-459-9790.

The annual meeting of the Board of Directors of the Rural Kentucky Medical Scholarship Fund, Inc is scheduled for Thursday, May 17, 1990, at KMA Headquarters. *kma*

KMA Member . . .
Auxilian . . .

Our readers are interested in the important events occurring professionally in the lives of their fellow members. Do you, or someone you know, have a newsworthy note to submit for possible publication in your *Journal of the KMA?*
If so, please submit in writing to:

KMA Journal
3532 Ephraim McDowell Drive
Louisville, KY 40205

MAY

16-19 — 13th Annual National Conference, "Rural Health! Empowered to Make a Difference," sponsored by The National Rural Health Association. Sheraton New Orleans Hotel, New Orleans, LA. Former US Surgeon General C. Everett Koop, MD, will present the conference's keynote address. Contact: Robert Quick, Communications Director, National Rural Health Association, 301 East Armour Blvd, Suite 420, Kansas City, MO 64111; (816) 756-3140.

18-19 — "Lipids: Regulation, Reversibility and Therapy," Hyatt on Capitol Square, Columbus, Ohio. Sponsored by Ohio State University Division of Endocrinology and Metabolism. Contact: Ohio State's Center for CME, (800) 492-4445.

19 — Trauma Symposium. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

20-26 — Twenty-First Family Medicine Review — Session II. Hyatt Regency Hotel, Lexington, KY. Presented by the University of Kentucky Office of Continuing Medical Education. Contact: Ms Joy Greene, Director, Continuing Medical Education, 132 College of Medicine Office Building, Lexington, KY 40536-0086, (606) 233-5161.

24-27 — "The Basal Forebrain: Anatomy to Function" — A conference to address why people forget; Hyatt Regency, Chicago, IL. Sponsored by the Neuroscience and Aging Institute at Loyola University Medical Center. Contact: Dr Napier, (708) 216-3261.

25-27 — Advances in Pediatrics. Marriott's Hilton Head Resort, Hilton Head Island, SC. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

25-27 — International Workshop on Californium-252 Neutron Therapy: Brachy and Boron Neutron Capture Therapy, Lexington Griffin Gate Marriott Hotel, Lexington, KY. Contact: Terry Stuart, Radiation Therapy Oncology Center, University of Kentucky Medical Center, Lexington, KY 40536-0084, (606) 257-4931.

JUNE

1-2 — 3rd Annual Contact Lens Course. Washington University Medical Center, St. Louis, MO. AMA Category 1 approved. Contact: Cathy Caruso, Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

4-8 — EVMS Family Medicine Review Course — Sixth Edition: Sheraton Beach Inn at Virginia Beach, Virginia. Sponsored by the Department of Family and Community Medicine of the Eastern Virginia Medical School. Contact: Office of Continuing Medical Education, EVMS, PO Box 1980, Norfolk, VA 23501-1980 or (804) 446-6140.

6-9 — Facial Rejuvenation — An advanced course for physicians having prior experience and knowledge of aesthetic facial surgery. Ritz-Carlton St Louis Hotel, St Louis, MO. Sponsor: Washington University School of Medicine. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St Louis, MO 63110; (800) 325-9862, (314) 362-6893.

6-10 — 7th Annual Meeting of the Southern Orthopaedic Association — Hyatt Regency Hotel, Maui, Hawaii. Category I CME Credits TBA. Contact: Jeanette Stone, Southern Orthopaedic Association, 35 Lakeshore Drive, PO Box 190088, Birmingham, AL 35219-0088; (205) 945-1848.

7-9 — Frontiers in Endosurgery: Flexible Endoscopy, Laser Surgery, and Endourological Techniques. For urologists only. Washington University Medical Center, St Louis, MO. AMA Category 1 approved. Contact: Cathy Caruso, Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St Louis, MO 63110; (800) 325-9862, (314) 362-6893.

9 — The Eye, Ear, Nose and Throat Update for Primary Care Physicians — Hyatt Regency, Columbus, Ohio. Sponsored by The Ohio State University Hospitals, The Ohio State University College of Medicine, Department of Otolaryngology and Department of Ophthalmology. Contact: Ohio State's Center for CME, (800) 492-4445 or (614) 292-4985.

14-15 — Cardiac Arrhythmias: Approach and Therapy — Hyatt on Capitol Square, Columbus, Ohio. Sponsored by The Ohio State University Division of Cardiology and Center for CME. Contact: Ohio State's Center for CME, (800) 492-4445 or (614) 292-4985.

14-16 — 35th Annual Great Smoky Mountains Pediatric Seminar, Park Vista Hotel, Gatlinburg TN. Sponsored by the University of Tennessee Medical Center at Knoxville. Contact: Continuing Medical Education or Sandra Loucks, PhD, Department of Pediatrics, 1924 Alcoa Highway, Knoxville, TN 37920, (615) 544-9331.

22-24 — Annual Meeting, The Virginia Society of Ophthalmology; Omni International Hotel, Norfolk, VA. Contact: Donna Scott, 4205 Dover Road, Richmond, VA 23221; (804) 353-2721.

22-24 — Clinical Pediatrics. Westin Hotel, Washington, DC. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd., PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

24-27 — 17th Annual Harvard Medical School Course on Intensive Care Medicine; "The Art and Science of Critical Care." Omni Parker House Hotel, Boston MA. Contact: Bart Chernow, MD, FACP (Course Director), Dept. of Anesthesia, Harvard Medical School/Mass. General Hospital, 32 Fruit St, Boston, MA 02114; (617) 726-2858.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

KENTUCKY — EM staff physician needed for rural community hospital in southeastern KY. Annual volume 11,000. Competitive competition $80,000-$120,000, plus malpractice procured for you. Independent contractor status. Send CV to James Ball, Coastal Emergency Services of Kentucky, Dept SMA, PO Box 639, Whitley City, KY 42653. (606)376-5083.

PULMONARY/CRITICAL CARE/INTERNAL MEDICINE — opportunity near Louisville, KY. Excellent schools and housing! Very busy, diverse practice affiliated with new 120-bed hospital. Strong guarantee and full benefits. Contact Teresa Owens, Tyler & Company, 9040 Roswell Road, Suite 550, Atlanta, GA 30350. (800)223-3659.

WESTERN KENTUCKY — Seeking physicians for evening and weekend coverage in a low volume emergency department. Attractive schedule and compensation. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc, 2240 S Airport Road, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

MEDICAL AND OFFICE EQUIPMENT FOR SALE — Exam table; Burton lamp; UV light with timer; Dazor portable lamps; Midmark power table; Exam stools; Mayo stand; IV Pole; Trash receptacle; Slide trays; Portable oxygen unit; 8" forceps with jars; 4 shelf storage cabinets; Ledger trays; 8" needle holders. Contact the office of Dr Judith McGuinn, Owensboro, KY (502)684-5808. Ask for Nancy.

EMERGENCY MEDICINE/KENTUCKY — Full/part-time Emergency Department positions for primary care physicians with ED experience and ACLS certification. Lucrative compensation and professional liability insurance procured on your behalf. Flexible hours, no overhead, choice locations. Contact: Ms Dianne Rabun at 800-777-1301. Coastal Emergency Services, Inc, Memphis, TN.

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"Hey guys, there's some smashing news about safety belts that you should know. And Larry and I want to be the first ones to break it to you."

"But Vince, we like to break everything."

LESSON NO. 1

"As you know, Larry, pretty soon all cars will come with automatic safety belts or air bags – and I don't mean your mother-in-law!"

"That's right, Vince, but these new automatic gizmos only do part of the job to keep you from being a windshield warrior. You've still got to make sure your safety belt is buckled up."

LESSON NO. 2

"Larry, do you know what works best when they fit tightly?"

"My Uncle Bernie's false teeth?"

"No Larry, safety belts. You've got to always make sure that yours is snug and that whatever safety belt system your car comes with is in a-ok-working order."

LESSON NO. 3

"No matter if you're on the road to Rio or going just around the corner, without a safety belt my friend you're on the road to ruin."

"Ruin, is that a small town in France, Vince?"

"No, dashboard breath, what I'm saying is whether your trip is short or long, you should be buckled up."

LESSON NO. 4

"And Vince, folks should remind others to wear their safety belts too. Remember there could be a dummy in your car."

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606/253-1371

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Owensboro, KY 42302
502/926-2806

HIGGINS INSURANCE, INC.
800 S. Virginia Street
P.O. Box 5
Hopkinsville, KY 42240
502/886-3939

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1536 Winchester Avenue
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Ashland, KY 41105
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129 E. Main Street
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FREDERICK RAUH COMPANY OF KENTUCKY
211 Grandview Drive
Ft. Mitchell, KY 41017
606/341-5722

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Louisville, KY 40299
502/499-6880

VAN METER INSURANCE
1719 Ashley Circle
P.O. Box 1779
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315 N. Main Street
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703 Jefferson Street
P.O. Box 1480
Paducah, KY 42002
502/442-3533

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Cincinnati, OH 45202
513/852-6300

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Philadelphia, PA 19103

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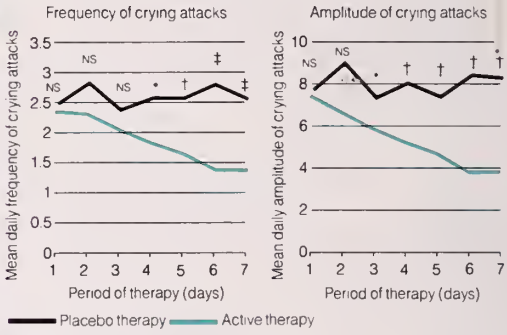

p values (active vs placebo) NS = Not significant •$p < 0.05$ †$p < 0.02$ ‡$p < 0.01$

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Helps you through the colic phase.

1 Kanwaljit SS, Jasbir KS. Simethicone in the management of infant colic. *Practitioner* 1988;232:508.

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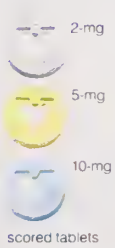

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A Continental Medical Systems facility

JOURNAL OF THE

KENTUCKY MEDICAL

ASSOCIATION

VOLUME 88, NUMBER 6 JUNE 1990

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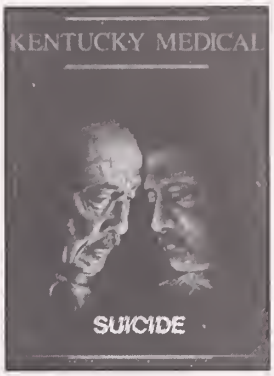

Cover: In our splendid cover art, illustrator N. Lee Wade captures a very sensitive portrayal of suicidal depression. Articles relating to suicide in the black and elderly populations begin on pages 287 and 301 respectively.

Mr Wade is associated with Wade Illustration & Design in Louisville.

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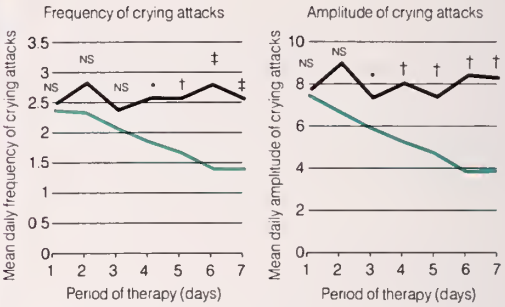

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Where Do We Go From Here?

In its annual report to Congress released in April 1990, the Board of Trustees of the Medicare Trust Fund said, "Soaring health care costs could bankrupt the fund that pays for hospital care before the turn of the century . . . early corrective action is essential in order to avoid the need for later, potentially precipitous changes." The hospital insurance fund is financed with payroll taxes. Currently, more than four covered workers support each beneficiary. This ratio will slip early in the next century, as the over-65 population increases, to just two covered workers supporting each beneficiary. The anticipated reserves in financing of Medicare programs are inadequate. Pessimists are predicting 1999 as the date the fund will be exhausted; optimists say 2018. The board report stated, "If economic growth is moderate, the Medicare Hospital Insurance Trust Fund will run out of money between 2003 and 2005."

'. . . Soaring health care costs could bankrupt the fund that pays for hospital care before the turn of the century . . . early corrective action is essential in order to avoid the need for later, potentially precipitous changes.'

Medicare's other trust fund, the Supplemental Medical Insurance Trust Fund, is now "actuarially sound," meaning that it should have enough money to meet its obligations under current conditions. However, the soaring costs of Medicare part B expenses (physicians and out-patient services reimbursement) have nearly doubled in the past 5 years. The Supplemental Medical Insurance Trust Fund, which receives 75% of its funding from general fund revenues and 25% from premiums paid by beneficiaries, is rapidly being depleted.

The Medicare program currently provides medical benefits to about 30 million Americans age 65 or older and 3 million disabled individuals. This report of the Medicare Trust Fund Board caused Health and Human Services Secretary Louis Sullivan to say, "These findings underline the urgency of our task in containing health care costs and spending our health care dollars more effectively and efficiently."

The above information is a condensation of an Associated Press Washington Bureau release which appeared in our local newspaper.[1] It just so happened that I read it the same day the young assistant administrator of our clinic came to my office to explain to me the impact on our group and my individual general surgery practice of the Bush administration's 5.5 billion dollar cuts, primarily Part B in the Medicare budget. He explained other cuts to be enacted later this year, the numerous coding changes to be made, and reminded me that this does not include the additional changes under resource based relative value scales to be enacted in 1991. Needless to say, all of this alarms me. First of all it alarms me that we need

'We need the support of every physician in Kentucky to change the attitudes of policymakers to a more sympathetic view toward physicians. Time is running out. If you are not already involved in organized medicine, put your shoulder to the wheel.'

an assistant administrator to translate and interpret government regulations which, of course, will affect my livelihood. More importantly, they will affect patient care — whom I may admit to the hospital and how long they may stay, what diagnostic tests I may order, and even in some instances, what surgery I may or may not perform. *I* am closer now than ever before, of course, to *being* one of these "Medicare recipients." The fact that the program may be bankrupt by the time I get there doesn't help. It seems that we physicians are being singled out for government regulation of our profession. It is indeed alarming that the restrictions and inconveniences forced upon us, intruding into every facet of our practice of medicine, may not be enough to provide ongoing benefits for future generations.

A recent nationwide survey, conducted by the Gallup organization, indicates that 64% of those surveyed who were not now eligible for Medicare said they did *not* expect to get the same benefit as today's Medicare beneficiaries. Only about half (47%) of those surveyed indicated they would be willing to pay more now to guarantee Medicare benefits later; 86% said they expected to need additional health insurance beyond what will be provided by Medicare.[2]

The results of this survey certainly indicate that the general public shares my concerns about the ability of the Medicare program to take care of us when we reach age 65, even at current care levels, which of course do not include long-term care in a nursing home, the most expensive facet of care of the elderly.

What is the solution to all this? Where *do* we go from here? A very wise Presbyterian minister once told me that most of life's problems had no solutions, only resolutions, often painfully negotiated with concessions made by all concerned. I certainly don't have the answer to the problems we face in providing access to health care to all Americans regardless of age or ability to pay. Possible solutions are out there, of course. We won't like most of them, such as a compulsory national health insurance including employer-pay coverage, (even for small businesses), rationing of health care, a slowdown in the development and proliferation of expensive technology, non-physician care providers, and the worst possible solution — abandonment of our free-enterprise health care system altogether.

We need the support of *every* physician in Kentucky to change the attitudes of policy makers to a more sympathetic view toward physicians. Time is running out. If you are not already involved in organized medicine, put *your* shoulder to the wheel.

Nelson B. Rue, MD

'Pessimists are predicting 1999 as the date the fund will be exhausted; optimists say 2018. . . . "If economic growth is moderate, the Medicare Hospital Insurance Trust Fund will run out of money between 2003 and 2005.'

. . . 'The soaring costs of Medicare part B expenses (physicians and out-patient services reimbursement) have nearly doubled in the past 5 years.'

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Intensive Care for Respiratory Failure in Guillain-Barré Syndrome

Betty Joyce, MD; Mark V. Burns, MD; Thomas M. Roy, MD

Although relatively uncommon, Guillain-Barré syndrome remains the most frequent cause of sudden weakness in persons under the age of 40 years.[1] *While most patients enjoy spontaneous resolution of their neurologic deficits, death still occurs in some individuals who suffer secondary complications from profound respiratory muscle weakness.*[2] *This review of patients with ascending paralysis who required intubation and mechanical ventilation underscores that the major factors which contribute to death and morbidity can be anticipated and largely avoided using a vigilant multidisciplinary approach.*

From the University of Louisville School of Medicine, Division of Respiratory and Environmental Medicine, 550 S Jackson St, ACB-3, Louisville, KY 40292.

Introduction

Physicians caring for patients suffering from acute polyneuritis with ascending paralysis are faced with a number of difficult diagnostic and management decisions. One of the most important clinical judgements is if, and when, mechanical ventilation should be instituted for respiratory support. While the overall mortality rate in patients with Guillain-Barré syndrome (GBS) is quoted to range from 3% to 6%,[3,4] the mortality of patients with progressive respiratory paralysis who require assisted ventilation increases to 25% to 30%.[5] These deaths are most often due to pulmonary complications or rarely to unexpected cardiac arrhythmias.[6] The tragedy is compounded by the fact that the lungs of patients with GBS are usually normal before the onset of paralysis. It is imperative that the primary care physician be aware of the potentially preventable complications associated with respiratory failure in the patient with GBS and reduce the mortality by timely interventions.

Patients and Methods

Forty patients admitted to Humana Hospital University of Louisville during the 5-year period from July 1, 1984, through July 1, 1989, with the diagnosis of acute idiopathic polyneuropathy and/or Guillain-Barré syndrome (GBS) were identified from the computer retrieval system of the medical records department. The hospital records of these patients were reviewed to determine the extent of the ascending paralysis and the use of assisted mechanical ventilation. Seven of 40 patients (17%) required intubation and mechanical ventilation. The medical records of this subgroup were audited for pulmonary complications that were identified by the primary physicians, consulting physicians, and radiologists.

The diagnosis of GBS was confirmed by a neurologist in each case using the criteria established by the National Institute of Neurologic and Communicative Disorders and Stroke (NINCDS),[7] and generally involved the presence of progressive symmetrical paralysis with loss of deep tendon reflexes, an absence of evidence of other causes of paralysis, and a subsequent course consistent with GBS.

Results

There were seven patients with GBS admitted to the intensive care unit for assisted ventilation during the 5-year study period. The group contained four males and three females with a mean age of 38.4 years, ranging from 20 years to 69 years.

The criteria used in the decision to intubate was a vital capacity (VC) of less than 15 cc/kg, a negative inspiratory force (NIF) of less than 25 cm of H2O pressure, or an inability to handle airway secretions. In each case, an elective controlled atraumatic intubation was accomplished. Frequent measurements of endotracheal cuff pressure were made daily in order to avoid overinflation of the high-volume low-pressure cuffs on the endotracheal tube. Each patient was supported with a volume-cycled ventilator. The mean duration of intubation was 19.4 ± 6.8 days, with a range of 5 days to 29 days.

Each patient received subcutaneous low-dose heparin prophylaxis to decrease the incidence of deep vein thrombosis and pulmonary embolism. Each patient was started on enteral feedings within 24 hours of intubation and received intravenous H2 blockers as prophylaxis against gastric stress ulceration. Every patient underwent plasmapheresis, receiving an average of four treatments. Four

Table 1. Guillain-Barré study patients (n = 7) and incidence of complications. (mean + SD)

Gender Male/Female	4/3	
Age in years	38.4 ± 18.6	
Days of Hospitalization	33.7 ± 16.4	
Days of Mechanical Ventilation	19.4 ± 6.8	
Normal Chest Radiograph on Admission to ICU	7/7	100%
Abnormal Chest Radiograph	6/7	85.7%
During Mechanical Ventilation		
Altelectasis or Collapse	4/7	57.1%
Lobar pneumonia	3/7	42.8%
Required Bronchoscopy	3/7	42.8%
Received Tracheostomy	2/7	28.5%
V/Q Scan for Suspected Pulmonary Embolism*	3/7	42.8%

* All V/Q scans for pulmonary embolism established low probability.

patients (57%) received intravenous immunoglobulin. Two patients (28.5%) received short course therapy with cortico-steriods.

Oxygenation was adequate on room air in each patient immediately prior to intubation as determined by the alveolar-arterial oxygen tension difference. Likewise, each patient's chest radiograph was interpreted as normal by the radiologist prior to intubation. During the course of ventilatory support, 6/7 (85.7%) patients developed abnormal chest radiographs consistent with atelectasis from mucus plugging and/or pneumonia. Table 1.

The duration of time between recognizable neurologic improvement and completion of weaning was an average of 5 days with a range of 2 to 12 days. In each case, successful weaning was accomplished by a SIMV protocol.

There was one death in this series which was secondary to an adverse drug reaction which resulted in cardiac arrest.

Discussion

Respiratory failure is the most common life-threatening complication from the ascending paralysis observed in patients with the Guillain-Barré syndrome (GBS). Approximately 15% of patients with GBS will require respiratory support with intubation and mechanical ventilation because of paralysis of the respiratory muscles.[8] Although the severity of GBS is reflected by the need for assisted ventilation, vigilance to potential complications has lowered the mortality of patients who need mechanical ventilation from approximately 30%[5,9] to 5% to 10%.[10,11] These deaths can usually be attributed to pulmonary complications.

The major responsibility of the primary care physician is to identify those individuals who need assisted ventilation. This may be difficult in patients who have a slow progression of paresis. Usually, the patient with rapid development of widespread and profound muscle weakness is more likely to require respiratory support. Investigators emphasize, however, that there are no characteristic neurologic features that reliably indicate the need for, or the expected duration of, assisted ventilation. For example, GBS patients with evidence of pharyngeal impairment, regardless of the degree of peripheral muscle weakness, require special consideration since cranial nerve dysfunction may allow aspiration and respiratory failure.

This problem can be easily overcome by using frequent objective bedside measurements of pulmonary function as criteria for intubation. A decrease in vital capacity to less than two times the predicted tidal volume or less than 15 cc/kg, a decrease in negative inspiratory pressure to less than 20 cm H2O pressure, or an inability to handle oral secretions are early indicators of the need for intubation.[6,11] Radiographic abnormalities and arterial hypoxemia with or without CO2 retention are late indications that mechanical ventilation should be undertaken. Their presence provides evidence that the lung is already significantly compromised. The use of the objective bedside measurements which allow early intervention have been shown to be associated with less pulmonary complications than "late" intubation.[9]

The timing of tracheostomy is controversial. While there are no clear guidelines, the general consensus is that it is safe to use the standard high-volume low-pressure endotracheal tubes for 21 days before sending the patient for tracheostomy.[12] However, some investigators insist that all patients with GBS will require prolonged mechanical ventilation and therefore require early tracheostomy.[13] Our experience, as well as others, does not bear this out.[6,11,14] In most recent reports, at least 50% of GBS patients required ventilatory support for 9 days or less.[14] In our study, the mean duration of intubation was 19.4 days. Based on these observations and the 7% to 55% incidence of complications associated with tracheostomy in the GBS patient,[11] it appears reasonable to employ

at least 2 to 3 weeks of endotracheal intubation before performing tracheostomy.[11, 15, 16]

Successful weaning correlates with improved respiratory muscle strength and is indicated by a measured vital capacity of greater than 1 liter, a maximum negative inspiratory force of greater than 20 cm H2O, and an effective cough.[11] It is important to recognize that the return of respiratory muscle strength does not necessarily correlate with limb strength.[14] The weaning parameters mentioned above need to be documented rather than assumed. Likewise, the ability to ventilate does not necessarily imply that the patient will no longer need an artificial airway. Pharyngeal competence must be demonstrated before the airway is removed in order to prevent aspiration and re-intubation.

The majority of serious complications associated with assisted ventilation during the transient paralysis of GBS can be anticipated. Since the lungs of the GBS patient are usually normal before the onset of paralysis, it should be possible to prevent lung disease and reduce mortality with proper interventions.

Mucus plugging to the extent that significant atelectasis or collapse occurs has been observed in 30% to 50% of patients.[10, 14] The early use of mucolytic agents may decrease this problem, but this has never been studied in a controlled manner. Because these patients lack an effective cough, attention to pulmonary toilet is essential. Chest physical therapy and frequent positional changes are important factors. Caution must be exercised by the health care team, however, since cardiovascular autonomic dysfunction is estimated to be present in approximately 65% of patients with severe GBS.[17] There are reports that chest percussion and airway suctioning can be sufficient external stimuli to exacerbate this cardiovascular autonomic dysfunction resulting in dangerous arrhythmias, hypotension, and cardiovascular collapse.[17, 18] Controlled therapeutic bronchoscopy has been helpful in our experience and in other studies.[10, 14]

Pneumonia may occur in as many as 73% of GBS on ventilators.[6, 11] Good pulmonary toilet and frequent surveillance of respiratory secretions with gram's stain and culture may be helpful to monitor colonization and infection. Prophylactic antibiotics are not indicated. Particular attention must be given to factors which might predispose to aspiration as a cause of pneumonia. This would include the potential dangers associated with suctioning, enteral feedings, antacids, and H2 blockers.

Pulmonary embolism has been reported to occur in 33% of GBS patients.[19] This incidence has likely decreased with the standard practice of using prophylactic minidose heparin in the intensive care unit. Unless absolutely contraindicated, low-dose heparin should be instituted in all GBS patients in the intensive care unit. Intermittent pneumatic calf compression, however, is thought to be potentially harmful since the fibular pressure may injure the demyelinated peroneal nerve and result in a permanent foot drop.[2, 11]

The single patient in our series who died emphasizes recent observations that patients with severe GBS and autonomic nervous system dysfunction may be ultra-sensitive to some medications routinely used in the intensive care unit such as morphine, furosemide, thiopental, dopamine, nitroglycerin, and suxamethonium.[17]

Many of the older reports on patients with severe GBS report prolonged mechanical ventilation of 2 to 3 months or longer.[10, 11, 14] In our study, the mean time required for mechanical ventilation was considerably less at 19.4 days. Factors contributing to this marked difference are difficult to assess retrospectively. It has been suggested by some investigators that the length of time on the ventilator is age related, with those under 45 years of age averaging 20 ± 5 days of respiratory support compared to the older group that required 56 ± 20 days.[20] Our patients had a mean age of 38.4 years and would be in line with this observation. Others have not found this age relation to be true.[10] The single significant treatment difference in the care of our patients as compared to the earlier studies was the use of plasmapheresis in all seven patients within 7 days of admission to the intensive care unit. Each patient received at least four exchanges (of 3 to 4.5 L) based on the patient's weight. The rationale for this procedure is the existence of a humoral factor that reproduces the histologic patterns of demyelination. Our favorable experience correlates with recent published data that document a more rapid recovery of GBS patients who required mechanical ventilation.[21]

Although complete functional recovery is the rule in GBS, the more severely affected patients requiring mechanical ventilation are expected to have a higher incidence of residual neurologic

disability of varying degree. Pulmonary impairment, however, can be decreased by the physician who anticipates the potential respiratory complications inherent in providing the paralyzed patient with ventilatory support.

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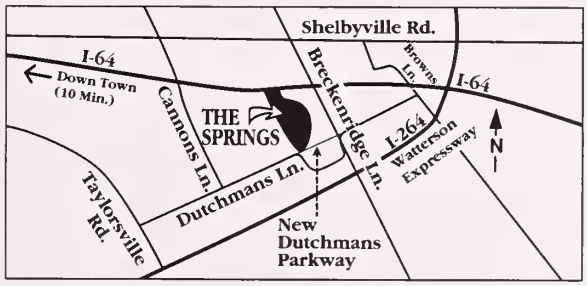

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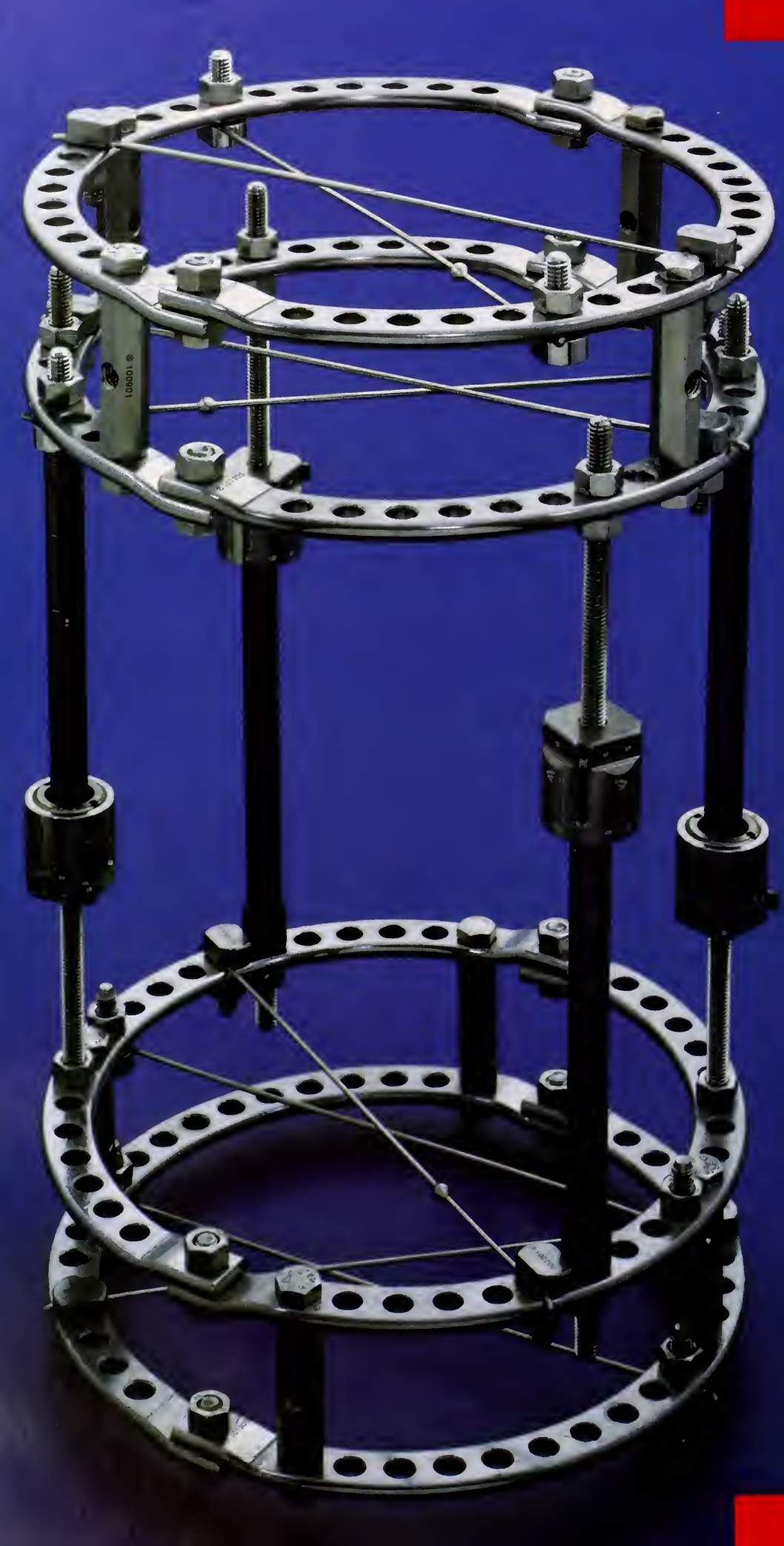

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Attempted Suicide by Black Men and Women: An 11 Year Study

Robert L. Frierson, MD, and Steven B. Lippmann, MD

Two hundred and thiry-two black patients (103 men, 129 women) who attempted suicide were referred for psychiatric consultation from January 1976 through August 1987. Black male attempters were (1) more often schizophrenic; (2) more apt to be intoxicated; (3) more commonly psychotic; and (4) more prone to use violent methods. Black women were more likely to manifest clinical depression and much more inclined to choose drug overdose as a method. Women were also more apt to jump from buildings or bridges and deliberately set themselves ablaze. Referrals of suicide attempters increased for both sexes over the study period, and violent methods, particularly firearm use, rose steadily among black women over the 11½ years. Recommendations for providing care to black suicide attempters include (1) appreciation of the psychological effects of racism; (2) increased sensitivity to depressive features in black schizophrenics; (3) consideration of affective disorders in young black males frequently involved in violent acts; and (4) awareness of one's own racially biased attitudes.

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Introduction

Suicide is a common cause of death in the United States.[1,2] Annually, almost 29,000 suicide fatalities are recorded, and suicide attempts are 8 to 10 times that amount.[1-4] Currently, about 6 million Americans have survived a suicide attempt.[5] Persons most likely to successfully complete suicide are white males age 45 and over and white females between the ages of 45 and 54.[5-7] Unsuccessful suicide attempters are generally young white females who act impulsively following an argument with a significant other.[8]

Many studies have contrasted white and nonwhite suicide attempters, and lower rates are generally reported for blacks.[9-14] Reasons for the comparatively small number of black attempters include (1) group solidarity fostered by racism and economic deprivation; (2) higher rates of violence among young black men that provide an alternate means of expressing anger and frustration; (3) the nurturing effect of the black church, community, and extended family; and (4) a tendency among young black males to emphasize survival over suicide as a means of resolving conflict.[8,15]

Few reports have specifically compared black men and women who attempt suicide.[8,14,15] Young black females, like their white counterparts, most often make a suicide "gesture" in the context of marital strife or problems with a relationship.[8-11] While black men who successfully complete suicide are usually in the third or fourth decade, some studies suggest that suicide attempts for black males over 50 are less common than those for white women and white men in the same age group.[9,11,15] Proposed explanations for lower rates of suicide attempts by older black males include emphasis in the black community on respect for the aged, and the gradual acceptance by elder black men of limited aspirations.[15] Other studies suggest that black women are increasingly choosing more lethal methods of suicide attempt such as firearms.[16,17] Black male attempters are often depicted as more prone to schizophrenia, mania, and psychosis.[8] Purported higher rates of schizophrenia among black males are often blamed on the preponderance of inner city males in most studies of suicide, and diagnostic biases on the part of mental health professionals.[8,15,18] According to Jones and Gray, ". . . being black and requiring psychiatric treatment carries a significant risk of being labeled schizophrenic."[18]

This manuscript reviews 129 black females and 103 black males who attempted suicide over an 11½ year period. These two populations of attempters referred for psychiatric consultation were compared for age distribution, marital status, method chosen, past psychiatric history, previous attempts, alcohol use, diagnosis, and disposition. Four representative cases are reviewed and recommendations offered for providing care to these patients.

Background/Method

The Louisville metropolitan area has a population of approximately 1 million people, 20% of whom are black. About 135 suicide fatalities are recorded by the Medical Examiner's Office annually. An average of 7 black men and 3 black women kill themselves in Louisville each year.

Patients were seen by the consultation psychiatry team at the University of Louisville School of Medicine. The 232 persons in this report represent 14% of the 1,725 suicide attempt referrals for all races, and 2.3% of the 10,350 total cases evaluated by the service over the 11½ year period. All black persons referred for attempting suicide are included in this report. Consultations were performed at the University Hospital, a 400-bed facility and area trauma center, and at three private hospitals, thus affording exposure to all socioeconomic levels. Each patient underwent a complete psychiatric evaluation, and diagnoses were determined based upon DSMII and III criteria. Recommendations concerning disposition and interim care were discussed with the referring practitioner. The data regarding black men and women who attempt suicide were analyzed for intergroup differences, variations over time, and correlation to other reported findings.

Findings

The 129 females and 103 males in this study represent a ratio of 1.25 to 1. The average age for black men was 30 years with a range from 14 to 56 years. For black women, the average age was 31.2 years with a range of 14 to 73 years. Eighty-four percent of black males were younger than 40 years of age, and only 4% were over 45. Four black females were over 60 years of age. Despite selected differences, overall age distribution did not vary significantly between the two groups. Age ranges for black men and women who attempted suicide are reviewed in Table I.

Table 1: Age Ranges far Black Male and Female Attempters

Age	Na.(%) Men	Na.(%) Women
14-19 years	10 (9.7)	19 (14.7)
20-29 years	48 (46.6)	47 (36.4)
30-39 years	29 (28.1)	32 (24.8)
40-49 years	12 (11.65)	23 (17.8)
50+ years*	4 (3.88)	8 (6.2)
TOTALS	103 (100.0)	129 (100.0)

* Na males were greater than 56 years af age.
ChiSq = 4.89.
df = 4.
p was greater than .05.
p value determined from Fisher RA and Yates F *Statistical Tables for Biological, Agricultural, and Medical Research,* (eds) 1948, published by Oliver and Bayd Ltd, Edinburgh and Landon.

The most common method of suicide attempt by both groups was ingestion of drugs or other substances, which was chosen by 88% of women and 57.3% of men. The most common drug ingested by males was phenytoin, and amitriptyline was most often taken by women. Men were more likely to ingest household cleaning agents, insecticides, and such materials as razor blades and glass. The second most frequent method for suicide attempts for both groups was a self-inflicted gunshot wound. The abdomen was the most common site of injury for both men (37.5%) and women (50%), followed by the head (men 25%, women 20%). Men were more likely to choose stabbing and carbon monoxide poisoning. Leaping from bridges and deliberate burn injuries were more common among women. Multiple methods were more frequent in men. Wrist cutting was evenly distributed between the two populations. Methods of suicide attempt differed quite significantly ($p < .001$) between the two groups. A comparison of methods of suicide attempt for black men and women is reviewed in Table II.

Seventy-one percent of males were single at the time of the attempt, 23.3% were married, 2.9% divorced, 1.93% separated, and 0.97% widowed. Among females, 62.8% were single, 25.6% married, 7.75% divorced, 2.3% separated, and 1.55% widowed. Differences in marital status were not significant.

Psychiatric diagnoses were compared for the two groups. Schizophrenia (22.3%) was the most common diagnosis among black men, followed by major depression (20.4%), adjustment disorder with depressed mood (15.5%), and alcohol abuse (14.6%). Among black women, major depression (32.6%) was the most frequent diagnosis, followed by adjustment disorder with depressed mood (19.4%), schizophrenia (11.6%), and alcohol abuse (8.5%). Psychosis at the time of the incident was three times more common in males. A past psychiatric history was present in 45% of males and 37% of females. A previous suicide attempt had occurred in 13% of men and 12% of women. Alcohol use during the attempt was much more common among males (27%) than females (11%). While individual variations are noteworthy for the two groups, the distribution of psychiatric diagnoses did not differ significantly ($p > .05$). Psychiatric diagnoses are reviewed in Table III.

All patients were questioned concerning precipitants for the suicide attempts. The most com-

mon reason among both sexes was difficulty with a relationship or marriage, and many persons attempted suicide immediately following an argument. The second most common rationale for women was a disagreement among members of the patient's family of origin (18%), followed by general dissatisfaction with life (10%), financial problems (4%), and job related difficulties (2%). Psychosis (13%) was the second most frequent precipitant among black men. One such person believed he had killed the president and deserved execution. Another psychotic black male attempted suicide by hammering a nail into his forehead. Perceived racism was more commonly alluded to as a predisposition to suicide by black men (4%). Financial and job-related difficulties, commonly cited precipitants for white attempters, were seldom mentioned as reasons by these 232 patients. Of the nearly 1,500 white suicide attempters referred during the study period, 30% listed job and money problems as precipitants to suicidality, compared to only 6% of black women and 2% of black men. Eight percent of black men did list unemployment as a rationale for suicide, however.

Inpatient psychiatric hospitalization was the disposition for 44% of men and 41% of women. Outpatient therapy was recommended for 50.4% of women and 41.7% of men. Other dispositions included referral to drug and alcohol treatment facilities (males 3.9%, females 3.1%), no follow-up desired (males 4.9%, females 4.6%), and jail (males 4.9%, females 1%). Referrals of suicide attempters in both sexes increased steadily over the 11½ years. From 1976 through 1980, 31 men and 38 women who attempted suicide were evaluated. From 1981 through 1985, the numbers increased to 53 males (a 71% increase) and 62 females (a 63% increase). Four clinical vignettes follow.

Table 2. Methods of Suicide Attempt for Black Men and Women

Method	No. (%) Men	No. (%) Women
Overdose	59 (57.8)	113 (87.6)
Gunshot Wounds	24 (23.5)	10 (7.75)
Others*	20 (18.7)	6 (4.65)
Totals	103 (100.0)	129 (100.0)

* Includes stob wounds, non-drug ingestions, corbon monoxide poisonings, motor vehicle occidents, leaping, hanging, wrist cutting, ond burn injuries.
ChiSq = 28.69.
df = 2.
p is less thon .001, highly significont.

Table 3. Psychiatric Diognoses for Block Male ond Femole Attempters

Diagnosis	No. (%) Men	No. (%) Women
Schizophrenio	23 (22.3)	16 (12.4)
Mojor Depression	21 (20.4)	42 (32.55)
Adjustment Disorder, Depressed Mood	16 (15.5)	25 (19.4)
Alcohol Abuse	15 (14.6)	11 (8.5)
Others	28 (27.2)	35 (27.1)

ChiSq = 8.82.
df = 4.
p greoter thon .05.

Case Reports

Case 1

A 28-year-old divorced black female was admitted to the burn unit after attempting suicide by setting herself on fire. The patient, a sergeant in the armed services, had become increasingly despondent over estrangement from her boyfriend. She experienced insomnia, anorexia, crying spells, and weight loss. Later, she developed hallucinations telling her to set herself ablaze. "I thought I would die instantly," remarked the patient, whose best friend successfully committed suicide by burning. The patient had a previous episode of depression without psychosis that culminated in a suicide attempt. On this evaluation, the patient was very despondent, but not psychotic. The diagnosis was major depression and brief reactive psychosis. Antidepressant medication was recommended and supportive psychotherapy provided.

This case illustrates a fairly uncommon method of suicide. The rationale for the attempt, ie, a problem with an interpersonal relationship, however, is frequently seen in most studies of attempted suicide. The next two cases illustrate the role of racism as a precipitant to suicidal behavior.

Case 2

A 19-year-old black male arrived at the hospital comatose after taking an overdose of ethchlorvynol. The patient had initially attempted to kill himself by driving his automobile into a telephone pole. Failing at that, he took the pills. Dur-

ing the evaluation, the patient reported despondency of about 2 months duration, and a previous suicide attempt by leaping from a two-story window. The patient claimed he had ". . . nothing to live for" because of losing his job, and ". . . constant mistreatment because of my race." The mental status examination revealed a depressed mood and residual suicidal ideation. He was not psychotic. The diagnosis was major depression, recurrent, and inpatient psychiatric care was arranged.

Case 3

Mr D, a 44-year-old black male was admitted after sustaining a self-inflicted gunshot wound. He reported increasing despondency after quitting his job, citing "racist attitudes" of his coworkers. Subsequently, he felt guilty due to inability to support his family. On the day of the attempt, his wife had left him, whereupon he shot himself in the head. He was not discovered until 4 days later. This individual had no prior attempts or psychiatric treatment. Mental status examination revealed a depressed mood and normal cognitive functioning; he denied residual suicidal ideation. The patient was maintained on suicidal precautions and transferred to the psychiatric unit when medically stable.

The preceding two case reports are fairly typical for those men who listed perceived racism as a contributing factor to suicidal behavior. Since most mental health caregivers are white, there may be significant underreporting of racism by black patients who attempt suicide. The possibility also exists that those patients who are severely depressed, have poor self-image, or are unable to tolerate stress, may be particularly prone to the psychological effects of sustained racism. The final case discusses the role of schizophrenia and acute psychosis in black male suicidality.

Case 4

Mr B, a 25-year-old black male with a history of schizophrenia, was hospitalized after hammering a nail into his forehead in an apparent suicide attempt. The precipitating event was a motor vehicle accident in which the patient hit another car. He panicked and became convinced that the police would ". . . put [him] away forever" or kill him. He left the scene of the accident and decided that he preferred death to being captured by the police, who, he claims, were tracking him with bloodhounds. The patient then smoked marijuana, with subsequent auditory hallucinations telling him to kill himself. Looking for a weapon, he initially tried to cut his throat with a piece of glass. Failing this, he discovered a nail and used a board to drive it into his head. To his surprise, this action did not kill him, or even inflict pain. Mr B assumed therefore that he ". . . could not be killed," wrapped his shirt around his head to conceal the nail, and surrendered to police. On psychiatric evaluation, he was fully oriented, alert, and cooperative. He denied psychotic features and did not show cognitive impairment. His affect was blunted and he denied residual suicidal ideation. The diagnosis was schizophrenia by history and acute organic (drug induced) hallucinosis and delusional syndrome. The patient's regular neuroleptic was restarted, and he was discharged to a substance abuse facility.

This last case is an example of the inability of many psychiatric patients to tolerate what is generally thought to be everyday stress. Such a minor incident as a traffic accident may lead to a chain of events culminating in suicidal behavior. Discussion and treatment recommendations follow.

Discussion

This manuscript has examined 232 black patients who were referred for psychiatric consultation after attempting suicide. An obvious limitation of such a study is that it cannot take into account those persons who attempt suicide but are not evaluated at a hospital. Thus we should not confuse actual rates of attempted suicide in the community with the rate of psychiatric referral for suicidal behavior. This report has considered three questions. What are the characteristics of black men and women who attempt suicide? How do findings in this study compare to previous investigations? Do these findings have treatment implications in the care of black patients who attempt suicide?

What are the characteristics of black men and women who attempt suicide?

Black male and female suicide attempters referred for psychiatric consultations were differentiated in terms of age, precipitants, psychiatric diagnoses, previous psychiatric history, and method chosen. In comparison to their female counterparts, black male attempters were (1) more commonly schizophrenic, (2) younger, (3) more often psychotic at the time of the attempt, (4) more inclined to be intoxicated during the at-

tempt and be diagnosed alcoholic, and (5) much more likely to choose a violent method such as firearms and knife wounds. Differences in terms of previous suicide attempts and marital status were not significant. The "typical" black female who attempted suicide was a 32-year-old single, depressed woman who impulsively overdosed because of problems in a relationship. She was more likely than the black male to be diagnosed with major depression. These features are similar to those of most white females who attempt suicide.[8] The "typical" black male referred for psychiatric consultation after attempted suicide was 30 years old, possibly schizophrenic and/or psychotic, who overdosed because of difficulties with interpersonal relationships. Thought disorders and altered reality testing are less commonly reported in studies of white males who attempt suicide.[8-12]

How do findings in this study compare to previous reports?

This study supports the findings of many previous reports on black suicide. Referrals of black males with suicide attempts after middle age were uncommon in this study, with the oldest such person being 56 years of age. This age distribution for black male attempted suicide has been reported elsewhere.[9, 11, 15] Some reports suggest that suicide attempt rates are highest in those persons disenfranchised by society. For white males this disenfranchisement generally occurs in old age. Black males, however, are often disenfranchised very early in life, accounting for higher attempt rates at an earlier age. Those older black men who have survived (or learned to tolerate) disenfranchisement often have accepted societal limitations, adapted their lifestyle accordingly, and may be less likely to attempt suicide. Indeed, some 20 years ago, Herbert Hendin attributed suicidality among young black men to ". . . a sense of despair, and a feeling that life will never be satisfying."[15]

Baker, in 1980, found higher rates of schizophrenia, mania, and psychosis in black male attempters compared to black women.[8] Our study supports these findings and further suggests that the number of black men, allegedly schizophrenic, who attempt suicide may be rising. This report suggests that referral rates for persons who attempt suicide are increasing for all populations. This rise is certainly multifactorial and may be related to (1) greater proficiency in trauma and emergency care and civilian cardiopulmonary resuscitation that has led to more of these individuals surviving and coming to the attention of psychiatrists; (2) a large upsurge in self-inflicted gunshot wound injuries as a method of attempted suicide; and (3) rising rates of psychostimulant and alcohol use by all populations.[16, 17] In this particular study, the local economy with elimination of many "blue collar" jobs by automation and other interventions may account for rising referrals of white, and to a lesser extent black, suicidal patients.

Our data shows a lower ratio of black female to male attempters (1.25/1) than in most reports, and a higher percentage of gunshot wounds to the head among black females (20%) of all deliberate firearm injuries.[4, 6, 7] These observations suggest that black women may be choosing and surviving more lethal methods of attempting suicide. Few recent reports have examined the effect of racism on suicidality in the black community. Our report suggests that for some black males, racial prejudice is a contributing factor in attempted suicide.

What are the treatment implications of these findings?

Recommendations based upon our experience in providing care to black suicide attempters include:

1. Develop a greater appreciation of the psychological effects of racism. Patient perceptions of racial prejudice are often dismissed by the physician as overreaction or paranoia.
2. Avoid overdiagnosing schizophrenia in young black men.
3. Increase sensitivity to symptoms of secondary depression in young male schizophrenics. Special attention to the emotional distress resulting from unexpected changes in the environments of these patients is essential. Support groups for young schizophrenics are helpful in this regard.
4. Be aware of one's own racially biased attitudes.
5. Recognize and treat psychotic features aggressively and educate patients and their families on warning signs of incipient psychosis.
6. Be familiar with, and utilize, various social agencies within the community.
7. Consider mood disturbances such as depression or mania in those young black males commonly involved in violent acts, either as perpetrator or victim. While seemingly not

suicidal, many such persons express despondency by ". . . little regard for their own welfare."

8. Gain some awareness of cultural norms in the black community.
9. Recognize that the black family, with its extended network, does provide support for members in distress and is an important resource to mobilize.
10. Involve, if at all possible, positive black role models in the treatment of young black patients who attempt suicide.

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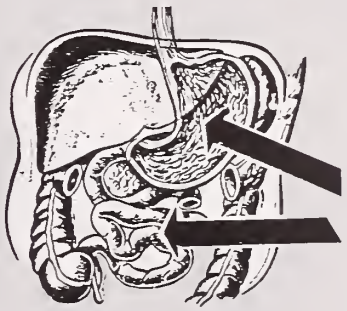

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Immediate Reconstruction of Bone and Skin Defects of the Humerus With Free Fibular Graft and Muscle Flap

Richard C. Sadove, MD, Ronald C. Burgess, MD

The following Case Report describes the immediate reconstruction of bone and skin defects of the humerus with a free fibular graft and muscle flap. A 33-year-old white female sustained a gunshot wound to the left upper extremity with a 3.08 caliber high-powered rifle. The entry wound was on the lateral aspect of her mid-arm. The exit wound on the anteromedial aspect of the upper extremity measured approximately 10 × 15 cm. A segmental loss of the middle of the humerus and a defect of the radial nerve were noted.

Within 48 hours after injury, reconstructive surgery was begun. A free vascularized fibula graft, peroneal artery, and concomitant vein were harvested from the left lower extremity, prepared, and inserted "peg in hole" fashion between the humerus fragments. The proximal segment was inserted between two fracture fragments, and the two fragments, including the proximal fibula, were transfixed with a single screw. The graft was revascularized with end-to-side anastomosis of the peroneal vessels to the brachial artery and its concomitant vein. The entire reconstruction was then covered with rotation of the latissimus dorsi muscle flap and a split-thickness skin graft. All wounds and the donor site healed primarily. Postoperative orthopaedic management consisted of maintenance of the external fixator for three months. Postoperative x-rays at 5 months showed healing at both ends of the fibular graft.

A history of free fibula transfers and a discussion of the importance of aggressive, early, bony reconstruction using the free vascularized fibula graft are presented.

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Introduction

The vascularized free fibula graft is a new surgical procedure which allows skeletal restoration of massive bone defects. This technique has the potential for broad application in the treatment of large segmental bone defects secondary to trauma or tumor resection. A multispecialty approach of combining plastic surgery and orthopaedic surgery is utilized.

Reconstruction of large skeletal and soft tissue deficiencies presents a major problem to orthopaedic and plastic surgeons. The past decade has witnessed significant improvement in the methods available for treating these problems. Microsurgical tissue transfer is now a routine procedure for closing soft tissue defects. The vascularized free fibula graft is a new development which allows skeletal restoration of massive bone defects and frequently avoids the need for amputation.

History

The history of free fibula transfer dates to Dr Ian Taylor of Australia. Dr Taylor first reported the use of the vascularized fibula transfer for a tibial defect in a 28-year-old man.[1] Several authors have reported the advantages of the free vascularized fibula graft for bone defects.[2-14] The traditional treatment for long bone defects of the humerus, for example, would be application of an external fixator, long term treatment to obtain skin defect closure, and cancellous bone grafting. It is difficult to obtain bone healing in such a situation due to the impaired vascular bed surrounding the bone graft and the prolonged immobilization and external fixator time required to obtain healing. With defects of the bone greater than 6 to 8 cm, free vascularized bone flaps are felt to have significant advantages over conventional treatment. The following case illustrates the usefulness of this reconstructive technique.

Case Report

The patient is a 33-year-old white female who sustained a gunshot wound to the left upper extremity with a 3.08 caliber high powered rifle (Fig

Fig 1 — Gunshot wound to the left upper extremity resulting in an anteromedial soft tissue defect and large bone gap.

Fig 2 — Angiogram of the left upper arm demonstrating patency of the brachial artery and severe comminution of the humerus.

1). The entrance wound was located on the lateral aspect of her mid-arm. The course of the missile resulted in an exit wound of approximately 10 × 15 cm on the anteromedial aspect of the upper extremity with a 20 cm segmental loss of the middle and distal humerus. The patient was taken to the angiography suite where patency of her brachial artery was demonstrated (Fig 2). She was then taken to the operating room where the humerous was stabilized with an external fixator. Debridement of the skin, soft tissue, and humerus was performed. A defect of the radial nerve was noted. The patient was dressed with the wound open and returned to surgery within 48 hours for definitive treatment.

A free vascularized fibula graft was harvested from the left lower extremity along with the peroneal artery and concomitant vein. The distal humeral segment was prepared by intermedullary widening to allow the free fibular graft to be inserted in a "peg in hole" fashion. A split in the proximal humeral shaft was utilized to allow bone coverage on both sides of the proximal fibular stump. The fibular segment was cut at an appropriate length. The excess length of bone was folded over to provide two vascularized fibular struts to bridge the humeral defect. One stump was transfixed to the distal humerus by inserting it into the medullary cavity and transfixing it with a 3.5 mm AO-lag screw. The proximal segment was inserted between two fracture fragments, and the two fragments, including the proximal fibula, were transfixed with a single screw. The extra fibular segment was turned 180 degrees to the first segment in a "double barrel" fashion and placed adjacent to the first graft without fixation. The extra segment was not long enough to span the entire bone gap. It was left in the wound rather than discarding in hopes that it would add to future stability. The graft was revascularized with end-to-side anastomosis of the peroneal vessels to the brachial artery and its concomitant vein.

The entire reconstruction was then covered with rotation of the latissimus dorsi muscle flap and a split-thickness skin graft. All wounds healed primarily. The anesthesia time for the reconstruction was 13 hours including closure of chest wounds.

Plastic surgical postoperative care consisted of frequent dressing changes as the split-thickness skin graft thickened and matured over the flap. No further treatment was required, and the donor site healed primarily. Postoperative orthopaedic management consisted of maintenance of

Fig 3 — Postoperative x-ray five months following humerus reconstruction. Screws internally fix the main bone graft. The second fibular segment demonstrates signs of bone bridging to the distal segment.

Fig 4 — Lateral postoperative view of the upper extremity three months following bone and soft tissue reconstruction.

the external fixator for 3 months. The patient was last seen 5 months following her initial injury at which time x-rays showed healing at both ends of the fibular graft (Fig 3). All of her wounds remained well healed, and she was working on regaining the range of motion of her upper extremity (Fig 4).

Discussion

The conventional treatment of a devastating injury such as this would involve the use of either a hanging cast or an external fixator, nonvascularized bone grafting of the defect, and prolonged wound care or other techniques to allow wound healing. The use of this conventional treatment plan presents many difficulties. The significant bone defect does not readily heal with the use of cancellous bone grafting and prolonged immobilization.[15] The possibility of repeated cancellous bone grafting is a significant disadvantage. With failure to obtain early closure of the wound, the possibility of osteomyelitis in this impaired vascular bed also remains a distinct probability and is a major disadvantage of this conventional treatment. Prolonged immobilization leads to decreased use of the upper extremity and decreased functional utilization of the immobilized shoulder and elbow while awaiting consolidation of the graft.

The conventional nonvascularized graft is thought to heal by creeping substitution. In creeping substitution the osteocytes of the graft perish,

and a major percentage of the bone is absorbed prior to replacement by new bone formation. The vascularized bone graft does not go through such a process. The osteocytes remain viable and sustain the bony substance. Primary bone union can take place at either end of the graft as in a conventional fracture. Maintenance of viability of the graft shortens the immobilization time. More rapid bony union can be achieved with the vascularized bone transfer. The disadvantage of the vascularized fibula graft lies in the lengthy operative time required for such a reconstruction. One of the three major vessels of the lower extremity must be sacrificed along with the graft.

Operative indications for the vascularized fibula graft are congenital pseudoarthrosis of the tibia, atrophic pseudoarthrosis after repetitive bone grafts, and bone defects after open fracture, tumor resection, and osteomyelitis. The Ilizarov technique of bone lengthening is one alternative to grafting which holds great hope for the future. Defects of greater than 6 cm require long periods of treatment with bone lengthening techniques.

Conclusion

The success of aggressive, early, bony reconstruction in this case study illustrates that the free vascularized fibula graft is indeed a valuable addition to the armamentarium of the surgeon. It allows treatment of devastating extremity injuries which had previously posed nearly insurmountable challenges. The combined multispecialty team approach to such complex injuries provides a high quality of care for these problems.

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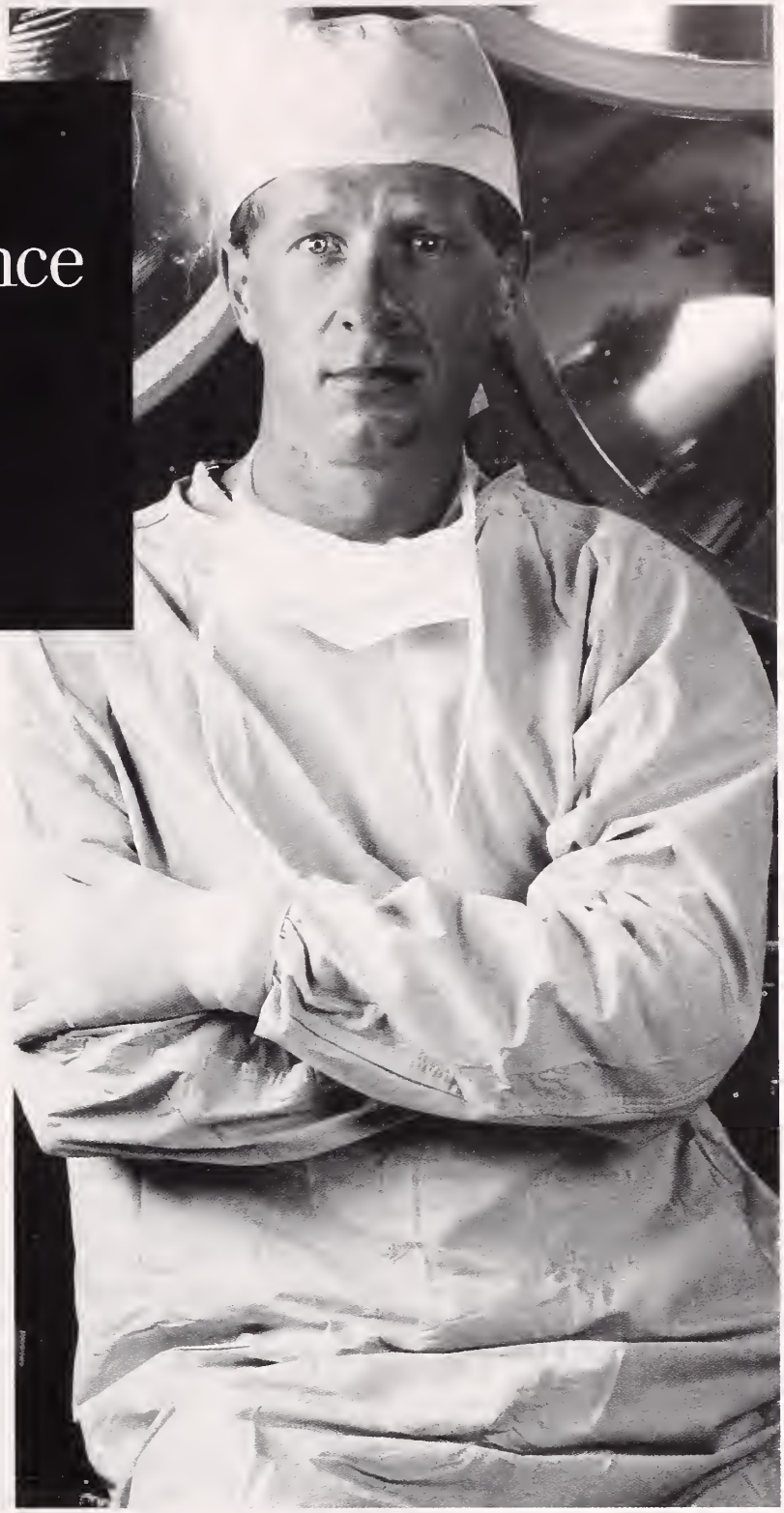

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JUNE

22-24 — Annual Meeting, The Virginia Society of Ophthalmology; Omni International Hotel, Norfolk, VA. Guest Speakers: James V. Aquavella, MD; H. Dwight Cavanaugh, MD; John D. Hunkeler, MD; Irvin P. Pollack, MD. Contact: Donna Scott, 4205 Dover Road, Richmond, VA 23221; (804) 353-2721.

22-24 — Clinical Pediatrics. Westin Hotel, Washington, DC. Contact: Suzanne Goheen, American Academy of Pediatrics, 141 Northwest Point Blvd, PO Box 927, Elk Grove Village, IL 60009-0927, (312) 228-5005.

24-27 — 17th Annual Harvard Medical School Course on Intensive Care Medicine; "The Art and Science of Critical Care." Omni Parker House Hotel, Boston MA. Contact: Bart Chernow, MD, FACP (Course Director), Dept of Anesthesia, Harvard Medical School/Mass General Hospital, 32 Fruit St, Boston, MA 02114; (617) 726-2858.

JULY

18-20 — "Development and Plasticity of the Spinal Cord" sponsored by Ohio State University's Center for Continuing Medical Education, the National Institutes of Health, the National Science Foundation and The Bowman Gray School of Medicine of Wake Forest University, at the Novice G. Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus, Ohio. The program meets the criteria for Category I of the Physician's Recognition Award of the AMA. Contact: Ohio State's Center for Continuing Medical Education, (800) 492-4445 or (614) 292-4985.

AUGUST

3-4 — "Management Of Post-Surgical And Post-Traumatic Complications In Orthopaedics" — Ritz-Carlton Hotel, St Louis, MO. Sponsored by Washington University School of Medicine. Program Chairman: Clayton R. Perry, MD. AMA Category I approved — hours to be determined. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St Louis, MO 63110; (800) 325-9862, (314) 362-6893.

8-12 — 3rd Annual Meeting of the Southern Association for Oncology, Orlando, FL. Contact: Kathy McLendon, Communications & Marketing Assistant, Southern Medical Assn, PO Box 190088, Birmingham, AL 35219-0088, (205) 945-1840.

18-25 — "Comprehensive Review in Internal Medicine" Conference; Hyatt on Capitol Square, 75 E State St, Columbus, Ohio. Sponsored by The Ohio State University Hospitals Department of Internal Medicine. Fees: $750 for the full week if registered before June 15; participants must register for a minimum of four days at $550. Approved for 77.5 Category I Continuing Medical Education credit hours. Contact: Ohio State's Internal Medicine Department — (800) 752-8606.

SEPTEMBER

28-29 — Fifth Annual Multispecialty Oculoplastic Surgery Symposium. A cojoint symposium by all specialties involved with the management of problems of the midface and ocular adnexa to discuss the state of the art solutions to the difficult situations in the realm of oculoplastic surgery. Contact: Karen Heidorn, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 North Eagle Creek Drive, Lexington, KY 40509, (606) 268-3754.

OCTOBER

14-17 — Southern Medical Association's 84th Annual Scientific Assembly, The Opryland Hotel, Nashville, TN. Contact: Kathy McLendon, Communications & Marketing Assistant, SMA, PO Box 190088, Birmingham, AL 35219-0088, (205) 945-1840.

NOVEMBER

1-3 — "Clinical Allergy for the Practicing Physician" — Sponsored by Washington University School of Medicine. Program Chairman: Phillip E. Korenblat, MD. AMA Category I approved — hours to be determined. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

Suicide in the Elderly

David A. Casey, MD

Suicide is more common among the elderly than any other age group. Elderly white males constitute the group at highest risk for suicide in the United States. Older persons typically choose means of high lethality in suicide attempts. Previous suicide attempts, bereavement, alcohol abuse, depression, psychosis, physical illness, and social isolation are all risk factors for suicide in the elderly. Clinicians who treat this patient group should have a high index of suspicion for suicidal ideation.

Suicide is a significant cause of mortality among the elderly. The demography of our society is changing, with the elderly forming an increasing portion of the American population. Because of these demographic changes, suicide among the elderly will be a major public health problem over the next 50 years.[1]

Suicide is more common among the elderly than any other age group. The suicide rate in Kentucky in 1988 for persons 65 and over was 22.2 per 100,000 population as compared to 13 per 100,000 in the entire population.[2] Among the elderly, the majority of suicides are committed by white males, whose suicide rates continue to climb throughout life. The suicide rate plateaus in late middle-age among white women, then tends to fall in old age. Suicide is relatively rare among minority elderly, particularly elderly black persons. Elderly persons typically choose highly lethal means of suicide, such as firearms, resulting in a high ratio of suicide completions to attempts.[3]

Suicide is usually related to a depressive disorder. Previous suicide attempts, alcohol abuse, bereavement, social isolation, psychosis and physical illness are all risk factors for elderly suicide.[4] Depression in the elderly may be difficult to detect, particularly because of the tendency of such patients to somatize rather than report emotional difficulties.[5] In fact, patients who later commit suicide have commonly visited a physician for a physical complaint in the period before the suicidal act.[6] Suicide among the elderly may be even more common than statistics show. Some suicides probably go unrecognized or unreported. In the absence of a suicide note or postmortem examination, some overdoses may be classified as natural deaths. In addition, refusal of food, medication, or other treatment may represent a passive form of suicide.[3]

Suicide in the elderly appears to be influenced by cultural as well as psychological factors. Patterns of suicide in most western societies are similar to the United States. In Japan, suicide rates among the elderly are higher and the disparity between males and females is much smaller.[1]

Clinicians who treat elderly patients should have a high index of suspicion for depression and suicidal ideation. In particular, white males should be assessed for suicidal ideation, especially if they have risk factors as previously noted. The availability of a lethal means of suicide, such as a firearm, should be determined. When elderly patients report suicidal ideation, they should be taken seriously given the high suicide rate among this population and the relative rarity of manipulative gestures. Patients with suicidal ideation should be referred for urgent psychiatric evaluation.

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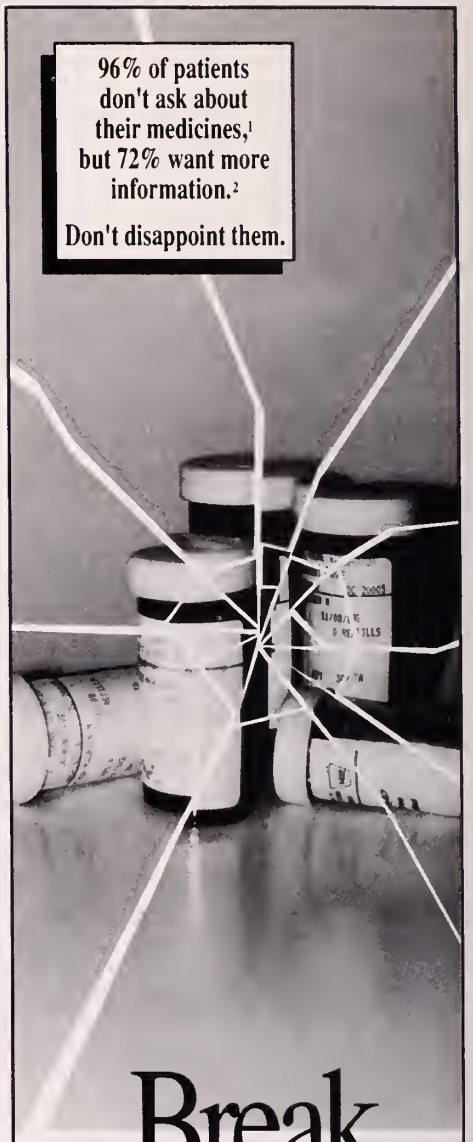

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[1] FDA survey, "Patient Receipt of Rx Drug Information", 1983

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General and Trauma Surgeon.
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EDUCATION University of Southern California, B.S.; University of California School of Medicine.

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HOSPITAL AFFILIATIONS St. Luke Hospital; Huntington Memorial Hospital, Pasadena, California; Traumatologist, Arcadia Methodist Hospital, Arcadia, California.

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Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Athletics and Danger

Sometimes it's the faster heart beat and other times it's the fresh cool beads of sweat on the brow. Lethargy from the night before is erased with the energy from thinking what is to come. Clothes are changed, tape and protections applied, and soon warmups ready us for the arena. Whether a crowd of onlookers awaits us, or only the quiet solitude of working out alone, some form of sound complements the rest of our senses. Adrenal glands pump their hormones — to fight or flight — and the rush of animation springs us to action. For the moment we feel omnipotent, taking little heed of possible calamity. Whether denial or experience governs, our thoughts are directed forward, our vision is to the task ahead.

Some of us are medically educated, some even bear the mantle of "sports medicine" person. Certainly we are comfortable with the responsibility of first aid, of tending to the injured to the point of cure, or at least preparing the person for the next step to help. However, I don't think any athlete, whether professional or amateur, saw the basketball player Hank Gathers fall to the floor and did not react. This Loyola Marymount star, perfectly honed to be a superstar of the future and leading the nation now in several basketball statistics, was stricken with a fatal heart malady. Forewarned in this case is not necessarily foretold. Doctors attending to him several months ago studied his collapse at the free throw line and decided to medicate his ailing heart, lest his heart's fickle electrical system would leave him vulnerable. Like the racehorse at the gate, this man could not be reined in. His bucking against the bridle of medication and its side effects made his doctors, trainers, and coaches uncomfortable and worried. Even a defibrillator warmed the bench, as if like a substitute, it could leap into the fray and rescue the player needing relief. As he lay seizuring on the floor, his heart defying the frantic calls of his body, no one perched over him could stop the inevitable. Paralyzed by the moment, their machinations seemed almost purposeless. Carried from the floor, with a stunned hushed crowd giving its last tribute in pantomime, Hank Gathers was to die in the emergency room despite all of modern medicine now finally in play.

His isolation from adequate help at his worst moment recalls one of an athlete's greatest fears. Running alone down the path, straining against the burden of weight training, one on one with a peer — nearly all of us engaged in sports have faced a similar prospect of being vulnerable without help. Even those of us who had the thrill of team sports shudder to think of the cold days on the field, of the hot times in the gym, when we only had our mates to aid us if trouble arose.

In reality participation in sports can be dangerous. Many of us examine our bodies, with physical examinations, laboratory analysis, even stress tests. Judged fit and sent into the heat of competition, we can only hope that such screening will identify any malefactor lying in the lurch. Periodically even great athletes are struck down. Jim Foxx, the archetypical distance runner, was felled by a heart attack on one of his many lonely runs. Football fields, basketball courts, tennis and racquetball courts, golf courses, etc — all have been scenes of sudden death. Hearts fail, brain vessels rupture, aortas tear, and all the training and all the muscle tone cannot put the athlete back on his or her feet.

Nevertheless life is to be lived and enjoyed when possible. Prepare yourself for the task ahead. Make sure that your body is tuned to what your will drives it to do. Foolish efforts may result in tragic overextension. We physicians know something of the frailty of human existence. We also are aware of the beauty and benefit of exercise, of shaping the body to truly be the temple of the mind. Make sure we educate those athletes we can, whether it be a first-timer, a couch potato, a dieter, or even someone who had success in other sports, to be prepared for the activities encountered. Tragic events happen and seem to come along regularly. Hank Gathers dared fate, going into a game with little or no medicine on board or in reserve, and tested himself not only against his opponents on the floor, but also against the resiliency of his wounded heart. He was foolhardy, but that quality made him a force in the contest, a gladiator pitting himself against that which would bring him down.

Experiences such as these tell us to respect our body, as well as our minds. Be an example to the public by appreciating the dangers of athletics and participating at all levels — as players, coaches, trainers, owners — with responsibility.

Stephen Z. Smith, MD

'Be an example to the public by appreciating the dangers of athletics and participating at all levels — as players, coaches, trainers, owners — with responsibility.'

Practice Made Perfect: The Physician's Guide to Communication and Marketing

Edna Kaplan, MS

Published by Barrington Press, 1990
Boston, MA 02215
$39.95

Practice Made Perfect is a comprehensive and quite literal presentation of material that is very much before us in medicine today. Both communication and marketing strategies are extensively discussed and their relationship emphasized. Ms Kaplan speaks from a perspective of her own education as a public relations specialist with a master's degree from Boston University's College of Communication. As the spouse of a physician and with experience managing a medical practice and now as an advisor to the medical community, Ms Kaplan sees the scene with a practical eye.

Initially she alarms us with the realities of the times. Not that we are unaware, but as if a town caller, she shouts the call to arms, the warning that to dally is to fail. The marketer in her wants to dress us with a holster bearing a weapon to make or keep our place in the economic community. Changing her hats like in a haberdasherie, she balances this somewhat belicose nature with the admonition that to not keep personal with our patients is to lose the battle in the end.

So called "conservative strategies" for adequate communication with our patients include starting with an intense practice assessment. Looking at staff and procedures like a watchmaker, she carefully cleans the parts and oils the squeaks, replacing worn out processes with fresh approaches. Using the mail, the telephone, the television, and radio, the physician should get the word out that quality care with feeling is there for the asking. Speaking to individuals or groups facilitates this introduction or maintainance program.

Switching again to her aggressive mode, Ms Kaplan acts like the advertising executive, pushing the reader to the front of the pack with marketing plans. Consultants, like coaches, shout the orders from the sidelines, urging us to take steps into the arena where we are anything but comfortable. Some of us energize when the red light of the camera catches our eye. Others of us have spent years in the trenches — hospital wards, clinics, or the front line of private practice — and are blinded by the limelight. Still others have worn the robe of academie, and feel it illegitimate to consort with the economic pros. Although accepting this diversity, Ms Kaplan emphatically states that the world today will not forgive our inertia. For each of us mentioned above, she has a strategy we can wear, like the good clothes sales person who can find some dressing for even the worst of bodies!! Some tailoring needs to be done often, but Ms Kaplan's book gives some of the nitty-gritty "how to" information.

Why read such a book when piles of "important" literature heaps high on our bed tables? Education is never wasted and the lessons of marketing and communication are there to be learned and put to use. Today's medicine is more diverse, more complicated and, yes, more competitive. Adaptation to this milieu, to the degree that each of us feels comfortable, is the story of this book.

Stephen Z. Smith, MD

The Other Drug Problem

David W. Kinnaird, MD

The continued graphic portrayal of the expanding use of illegal drugs, particularly "crack," suggests we are losing the battle to contain our nation's thirst for such devastating substances. Faced with overwhelming demands on our criminal-justice system and fiscal resources in the ever expanding drug war, we may soon be further assaulted with another equally sinister drug, an illegal amphetamine derivative called "ice," which is making headway in Hawaii and is predicted to be on a mainland U.S.A. course.

'Use of illicit drugs is often labeled "recreational" while our polite society terms use of alcohol "social." Is there any real difference?'

While pondering this disturbing state of affairs, I experience a queasy feeling deep inside which seems to say that the solution to the drug crisis is hampered by our widespread citizenry's infatuation with, and often abuse of, alcohol — a mostly legal drug! We tend to minimize or ignore alcohol's and illicit drugs' shared characteristic as mind altering substances with a remarkable ability to effect a "high" or euphoria-like-state in the user. Use of illicit drugs is often labeled "recreational" while our polite society terms use of alcohol "social." Is there any real difference?

Though alcohol derivatives and illegal drugs have distinct pharmacological and physiological differences, both groups are highly addictive with a remarkable contagious propensity for unwary users. Not infrequently, some form of distilled spirits is the "entry" and "backup" drug in the Polydrug Abuse Phenomenon, so often incriminated in the rising number of admissions to drug rehabilitation centers in this country. Drug case files are replete with those situations where the adolescent drug abuser's parent or parents are known alcoholics, thus complicating treatment strategies for these young victims. These and other associations suggest that illegal and legal drugs are parallel and interrelated problems that cannot be separated. Success in the war against banned drugs depends on tempering our society's use of the legal drug — alcohol.

There's no need to recount to you knowledgeable readers the staggering cost, monetary and emotional, to our society as a consequence of our seemingly casual attitude toward use of alcoholic beverages. However, I cannot resist calling your attention to Jefferson (Ky) County's record of some 4,000 citations issued to persons charged with driving under the influence of alcohol (DUI) — a sobering statistic and further indictment of our failure to address the problem of whiskey and beer intoxication in operators of motor vehicles.

'. . . we need to dip down into the deepest recesses of our moral resolve and find the strength to challenge our nation's weakness and susceptibility for indulgent use of alcoholic drugs.'

Should we not listen to the beleaguered South American leaders who are warning us that illegal importation of drugs into this country depends upon abolishing or slaking the thirst and demand of our people for cocaine and similar drugs? Does this not also apply to our ethanol abuse problem? Our history is replete with failed legislative attempts to control excess whiskey and beer use, thus lending support to the conclusion that edict or governmental pressure will never serve to force public moderation in the use of any drug. The answer to

'Drug case files are replete with those situations where the adolescent drug abuser's parent or parents are known alcoholics, thus complicating treatment strategies for these young victims. These and other associations suggest that illegal and legal drugs are parallel and interrelated problems that cannot be separated. Success in the war against banned drugs depends on tempering our society's use of the legal drug — alcohol.'

this vexing problem must come from within the resolve of our people. In the past, nothing really seemed to stir this country into action except peoples' movements such as Women's Suffrage, Civil Rights, and the Equal Rights Amendment. Perhaps the time is ripe for launching a nationwide effort to modify our acceptance of alcohol use as a catalyst for social intercourse.

Authorities on drug abuse stress the importance of limiting exposure of young people to the risks of drinking alcohol and, indeed, much has been accomplished by educational programs directed toward substance abuse in the early, formative years in school. Does it not seem wise to expand this approach by adoption of the "Safe Homes" concept where parents join in an association which promotes and publicizes a listing of those homes where the parents attest not to use or store any ethanol or controlled substances on the premises? Such a promotion through groups, such as parent-teacher associations, would have the potential for rallying young families toward a more active role in limiting the exposure of their children to the menace of alcohol usage. On a larger scale, we adults should seek alternatives to drug "highs" by embracing non-drug "highs" from other activities. These efforts would serve to counter the pervasive promotional pleas for "happy hours," which are simply drug rituals. The insidious TV ads depicting scenes of group activities involving drinking beer with catchy slogans such as, "Guys, it can't get any better than this," should be banned through community action. Enactment of pending legislation establishing and enforcing clear labels on alcoholic beverages warning of addiction risks should be vigorously pursued in all states. The highly unconscionable common practice of selling beer at gasoline and food marts should be recognized as an invitation for disaster for the naive and susceptible young driver. Appropriate controls should be sought for this mischief. Likewise, the prominent merchandising of alcoholic beverages in drugstores and supermarkets should be cited as an unhealthy practice and brought to a speedy end. Further, it would make sense that drugstores which dispense medicines and health supplies should be designated and operated as pharmacies or apothecaries rather than DRUGstores. The latter title should be reserved for stores that dispense liquor and beer!

Finally, rest assured that I do not sound a call for total abstinence or prohibition of sales or use of alcohol, as this has proven to be a Camelot dream. I do believe that we need to dip down into the deepest recesses of our moral resolve and find the strength to challenge our nation's weakness and susceptibility for indulgent use of alcoholic drugs. Confronted by my own history as a controlled or social user of distilled spirits (my old college mates will likely applaud this turn of events), I wonder if our former President Theodore Roosevelt had the likes of me in mind when 100 years ago in the course of a New York Senate debate on the Prohibition controversy he said, ". . . yet, this evil [alcohol] could hardly be cured by the efforts of intemperate friends of temperance."

Nevertheless, I can be persuaded that it is time for a change in our mores as regards the use of booze. Addressing this challenge in a realistic and determined manner might well be a telling blow in the war against "crack" and similar illegal drugs!

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Is Your Spouse Foolin' Around?

A good and worthy question, especially if your spouse is a member of the Auxiliary to the Kentucky Medical Association. What about these "strange" projects that auxilians undertake? What's this secret outfit called AMAERF?

The truth of the matter is that auxilians can be very busy in their efforts, so busy in fact, that there is little time to fool around.

The current KMA president, Dr Nelson Rue, as well as the past presidents of the Kentucky Medical Association are believers and supporters of the auxiliary. They see and are impressed with the good works and the results they show.

Just the other day, as on many occasions, a "shower" was held at a county auxiliary for Ronald McDonald House. Gifts included ordinary everyday items — items which we take for granted. Ronald McDonald Houses are always in need of soap, towels, tissue, toothpaste, etc, for their visitors. In Louisville, similar projects have netted the same results for Covenant House. (Covenant House is a home for homeless men.)

McDowell House, as most of you know, is the historic home in Danville where the world's first ovariectomy was performed. Money is made from many projects and efforts to support and supply the home with necessary items. Needs this year run from $29.95 lamps to a new roof costing thousands. Another far cry from "foolin' around."

This strange and secret outfit called AMAERF, better known as the American Medical Association Education Research Foundation, always profits by the work done by auxilians in Kentucky. This year alone, over $60,000 was raised by hard work and no foolin' around. (Just ask the chairman and her cohorts that worked on this project.)

If your spouse needs a rewarding and enjoyable time and will give a helping hand, have him or her join the Auxiliary to the Kentucky Medical Association and find out how much fun "foolin' around" can be.

Betty Schrodt
AKMA President

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QUIT

American Heart Association

'Mrs KEMPAC' is Retiring

Fay Miles, the current employee with the longest association with KMA, is retiring as Executive Director of KEMPAC. June 14 will be her last day in the KEMPAC office. On June 18 she and her husband John, along with one of her sisters and her husband, will leave for an extended vacation and sightseeing trip through several southwestern states including Colorado, Nevada, California, Texas, and into Mexico.

Fay has graced the KMA offices with her sparkling personality and hard work for over 31 years, spanning the terms of 15 KEMPAC chairmen, beginning with Harold B. Barton, MD, through the current chairman, David B. Stevens, MD. Born Beulah Fay Stayton in Colesburg, Kentucky, Fay joined the Association on October 4, 1958, as secretary for the Advisory Committee to the Blue Cross-Blue Shield Board. She began her long-term dedication to the affairs of KEMPAC on April 1, 1966. On April 9, 1986, she was officially declared the Executive Director of KEMPAC. However, her fellow employees knew Fay had been the "executive director" since the first day she entered that office.

KMA Executive Vice President Robert G. Cox, the person who has spent the most years working with Fay on the KMA and KEMPAC effort, is quick to praise her. "Fay's dedication to the medical profession and its organizations, like KMA and KEMPAC in Kentucky, just could not be surpassed. Her 'recipe' of mixing medicine and politics has won many awards for us during her tenure. Her longevity 'in office' is a tribute to her professionalism. Most of all we'll miss Fay as a great person and friend, but her enthusiasm and spirit will remain and continue their positive influence on all of us."

'We'll miss Fay as . . . a great person and friend, but her enthusiasm and spirit will remain and continue their positive influence on all of us.'

In June, as she turns over the responsibilities of the KEMPAC office, Fay can point with pride to a KEMPAC membership that has grown substantially. In addition to her general office duties, she has assisted with countless other activities, has always arranged a very effective and entertaining KEMPAC Seminar during the Association's Annual Meeting, and has arranged and conducted numerous political seminars which in turn served as a catalyst for many physicians and their spouses to become involved in the political arena. Major Association changes during Fay's tenure have included a new office location, with two building additions to that location, and a KMA membership growth from 2,212 to 5,135.

Fay has been married 43 years to John Miles, who retired several years ago following a long and productive career with South Central Bell. Their life has been centered around their family of four children and thirteen grandchildren. Eldest son Danny is employed with General Electric in Connecticut, where he and his wife Carolyn are raising two children. Son Rick, a family practitioner and KMA member, lives in Russell Springs with his wife Terry and their three children. Daughter Marilyn, employed by the Jefferson County Board of Education, and husband Wayne live in Louisville with their four children. The youngest

'Mrs Kempac' is Retiring

There were beautiful roses, gifts, and, of course, many friends when Fay was honored at the KEMPAC Seminar last fall. She is pictured here with former KEMPAC Chairman Harold L. Bushey, MD, and his wife Eulene (center), and her long time co-worker and close personal friend Lillie R. Byrd, KMA's Director of Financial Operations.

daughter, Susan, after spending several years as a KMA employee, is now associated with a radiology center. She and her husband Nick have four children and live in Louisville.

In addition to managing a home that is the central "meeting place" for all important occasions for her immediate family, Fay is frequently entertaining overnight guests, both friends and extended family. Her energy and hospitality seem endless. She is active in community affairs, her church, and can be found gardening, both flowers and vegetables, in her "spare time."

Fay's career with the Association and KEMPAC have been mutually rewarding. At the 1989 Annual Meeting she was honored by the KEMPAC Board for her meritorious service. Included among the many dignitaries in attendance were Kentucky's Honorable Lieutenant Governor Brereton C. Jones and several former KEMPAC Board chairmen and KMA presidents.

Fay is very humble regarding her many years of unselfish dedication and service to the Association and her fellow employees. She is quick to express appreciation for the rewarding opportunity the medical profession has given her and for the kindness and loyalty of the hundreds of professionals she has worked with and for.

"Mrs KEMPAC's" 31-plus years of committed service and valued congeniality cannot be replaced. Fay Miles is unique, and her dedication to the Association has been unique.

And so upon her retirement, the Association and her fellow employees wish to say — "Bon voyage for your travels, and our sincerest best wishes for many relaxing and fulfilling years ahead. We will miss you, Fay." *kma*

PEOPLE

Two KMA members were recently honored as alumni fellows of the University of Louisville.

Marie M. Keeling, MD, and **Loman C. Trover, MD**, were two of 11 distinguished alumni selected as fellows for outstanding accomplishments in their respective fields. The Alumni Fellow title is a newly established award which will be conferred annually by each school of the University and will be conferred for life.

Dr Keeling, who is widely recognized as an authority on autologous blood transfusion, was presented with a bronze medallion at a reception at the J. B. Speed Art Museum.

She is director of transfusion services and hemostasis laboratories at Norton and Kosair Children's hospitals, and also serves as the medical director of the University of Louisville medical technology program and associate clinical professor of pathology, anesthesiology, and pediatrics.

Dr Keeling is a pioneer in the field of autologous blood transfusion, which is the storing of a patient's own blood for surgery.

Dr Trover, an Earlington physician who co-founded the Trover Clinic, received a bronze medallion at a reception in the Jefferson Room of Grawemeyer Hall. He was honored as the first recipient of the School of Medicine because of his significant contributions to medicine in western Kentucky for over 40 years.

A 1947 graduate of the U of L School of Medicine, Dr Trover, his brother **Faull Trover, MD**, and three other physicians, **Fred Scott, MD, John Haynes, MD,** and **Merle Mahr, MD,** established the Trover Clinic and adjoining medical facility, which includes a state-run school for training medical personnel for Hopkins County.

Dr Trover is past president of the American Group Practice Association and was the first president of the American Academy of Medical Directors. He has served on the board of directors of the U of L Cancer Center.

KMA members **Nigel Harris, MD,** and **Jon Klein, MD,** were included among the recent recipients of U of L's Young Investigator Awards.

Dr Harris, rheumatology, is the cental player in the international studies of anti-phospholipid syndrome, according to his division. The syndrome leads to blood clots and fetal loss.

According to the nomination, he was the principal organizer of four international symposia on his area of medical expertise, and he also organized the first book on the subject.

Recently Dr Harris' work has averaged about 200 citations annually in medical literature.

"This is outstanding," wrote division chief **Peter Hasselbacher, MD,** and acting medicine chair **Richard N. Redinger, MD.** "It reflects both the clinical and scientific importance of the new pathophysiological insights offered by the syndrome and also the high esteem of the international community for Nigel's scholarship."

Dr Klein, nephrology, is researching the intracellular events that accompany immune cell stimulation and studying the effects of new monoclonal antibodies on transplant organ rejection.

He has worked with other U of L investigators on clinical studies of the immune system. Dr Klein is co-director of U of L's Adult Transplantation program at Jewish Hospital and director of U of L's Histocompatibility Laboratory. He also is an ad-hoc member of two National Institutes of Health study sections.

Division chief **George R. Aronoff, MD,** nominated Klein "because of his prolific track record in nationally and internationally recognized scholarly research, his recognition as a rising young thought leader, and the recognition of his scholarly efforts by funding agencies."

Frank B. Miller, MD, assistant professor of surgery, and **Thomas J. Zimmerman, MD,** chairman of ophthalmology and visual sciences, were honored by U of L's Office of the President at commencement for outstanding contributions to the university during the past year. Dr Miller received the Distinguished Teaching Award in the professional category. Dr Zimmerman received the President's Award for Outstanding Scholarship, Research and Creative Activity in the basic and applied sciences category.

UPDATES

New Publication Helps Physicians Decide if Incorporation Still Offers Advantages

Does it make sense with the new tax law for your practice to be incorporated? The all-new edition of *A Physician's Guide to Professional Corporations* can help answer this question.

According to information from the American Medical Association, the book explains the pros and cons of incorporation, and clearly outlines legal and tax implications. It clarifies the rules of operating a professional corporation by translating this complex issue into common terms using a point-by-point approach.

A Physician's Guide to Professional Corporations, OP 378289, is available at $18 for AMA members ($27 for nonmembers), from the AMA, Book and Pamphlet Fulfillment, PO Box 10946, Chicago, IL 60610-0946, or call 1-800-621-8335.

Innovative Program Promotes the Arts as Medical Tool

Music, painting, sculpture and humor are being tested as treatment for chronic illness through a new program led by University of Louisville psychiatrist **Joel Elkes, MD.**

Through the Arts in Medicine program, Vietnam veterans use sculpture to express pent-up feelings of anger and frustration. Nursing home residents lighten their sometimes oppressive atmosphere by playing musical instruments. Effects are measured on patients' moods, activities, and life adjustments. U of L reports results to date have been encouraging.

Digital Images Provide Safer, Faster Cardiac Catheterization

University of Louisville doctors are getting a better picture of treatment for patients with clogged coronary arteries.

U of L is one of five sites nationwide that use biplane digital imaging equipment to more accurately view the blockages. Two cameras simultaneously photograph the arteries from different directions, delivering high-quality, computer-enhanced images.

The system is faster, uses lower doses of radiation and requires less dye contrast to be injected into the arteries than other treatments, says cardiologist **David Talley, MD.**

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

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Keith J. Alexander, MD — OTO
120 N Eagle Creek #111, Lexington 40509
1984, Ohio State U

Wayne B. Graff, MD — ANES
3320 Tates Creek Rd #204, Lexington 40502
1984, Columbia U

Kathryn L. Hettel, MD — PMR
121 Johnston Blvd, Lexington 40503
1984, Medical College of Ohio

Robert J. Homm, MD — REN
4569 Longbridge Ln, Lexington 40515
1980, U of Louisville

Kimberly S. Winchester, MD — ANES
2046 Old Nassau Rd, Lexington 40504
1985, U of Kentucky

Jefferson

Erle H. Austin, III, MD — TS
6911 Bridgepointe Blvd, Prospect 40059
1974, Harvard Medical School

Russell

M. D. Phelps, MD Life Member — C
RR 2, Box 203C, Jamestown 42629
1947, U of Louisville

New In-Training

UK —
Kathleen J. Bos, MD — **RHU**

UL —
Leela Bhupalam, MD — **P**
Terrance C. Devlin, MD — **ORS**

CORRECTION: The April issue of *The Journal* listed the specialty of Jeffrey Salon, MD, as EM. This should have been CCM.

DEATHS

Durrett C. Bennett, MD
Beaver Dam
1925-1990

Durrett C. Bennett, MD, a general practitioner, died March 5, 1990. Dr Bennett was a 1952 graduate of the University of Louisville and had been an active member of KMA since 1955.

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140TH KMA ANNUAL MEETING OFFERS A WEALTH OF ACTIVITIES

Scientific Sessions

The Hyatt Regency Hotel and Commonwealth Convention Center will host the 1990 Annual Meeting. The Scientific Program Committee has invited speakers from across the nation to participate in the sessions to be held during the mornings of September 25, 26, and 27.

Specialty Groups

Programs for 21 specialty groups will be held during the afternoons of September 25, 26 and 27. No general sessions are scheduled during the specialty group meetings and all KMA members are invited. Scientific sessions and specialty group meetings will be held in the Commonwealth Convention Center. By completing CME sign-up sheets at the beginning of each meeting, physicians attending general sessions and specialty group meetings will qualify for Category 1 Credit.

KMA House of Delegates

The opening meeting of the House of Delegates will be held Monday, September 24, at 9 AM in the Regency Ballroom located in the Hyatt Regency Hotel. Reference committee meetings will begin at 2 PM on Monday and the final meeting of the House will begin at 7 PM Wednesday, September 26. Officers for the 1990-91 Associational year will be elected during the final House meeting.

Other Activities

The 28th Annual KEMPAC Seminar will be held Monday evening, September 24, in the Regency Ballroom, located in the Hyatt Regency Hotel. A reception begins at 6 PM with dinner at 7 PM, and the program to follow at 8 PM.

The President's Luncheon will be held September 26 with presentations of KMA awards and the installation of the 1990-91 KMA President, Preston P. Nunnelley, MD.

Scientific and Technical Exhibits will be on display featuring new medical products, services, and techniques. Members and guests have an opportunity to visit this area during the 30-minute intermissions scheduled throughout the general sessions and specialty group meetings.

Pro Advisory Committee

THE KMA PRO Advisory Committee has met regularly the past few months with representatives of Sentinel Medical Review, the professional review organization for Kentucky. The meetings were prompted by a series of incidents where individual physicians expressed concerns over review outcomes conducted by Sentinel. As a result of the meetings, a great deal of helpful information has been exchanged and the Committee has invited Sentinel to work together with KMA to begin a new communications process to advise physicians of PRO operations and rule changes as they occur. *kma*

Choosing a Health Plan

One of the problems with health insurance that physicians continually hear about from their patients is that patients aren't sure what types of coverages they should buy and many times find out after they have purchased a plan that it contains a number of exclusions or benefit limitations.

The Kentucky Medical Association has developed the following guide which we hope will aid individuals in their decision making process regarding health insurance.

Please feel free to remove this page and reproduce it as you feel appropriate. We hope you will find this information useful.

What You Should Ask About Your Health Insurance

- May I choose my physician?
- Is my current physician a member of the plan?
- Will my prescription be paid?
- Are x-rays covered by the plan?
- Are office visits covered? Shots (injections)?
- Can I freely choose to see a specialist or must I be referred by my primary physician?
- Does my primary physician control access to specialty consultation?
- May I choose my hospital?
- Will lab tests be paid?
- Will specialists' services be covered?
- Must I have certain surgical procedures done as an outpatient?
- Will I be screened by medical personnel other than a physician before I see my doctor?
- Do I have easy access to a physician on week nights and weekends?
- Will my health care plan cover me for cost of medical treatment at out-of-town facilities when I travel?
- Will dependents be covered if they reside out-of-state?
- Can I get medical advice from a physician over the telephone during nonoffice hours?
- Am I limited to a certain number of routine care appointments?
- Must I schedule my appointments for routine care far in advance?
- Are any illnesses excluded from the coverage?
- May I request a "second opinion" from an outside physician? If so, will I have to pay for it?
- Will I have to pay a deductible or partial payment?
- When and how often are premium rates subject to change?
- Can I be let go from the plan without advance warning or if I use it too much?
- Do I have to fill out claim forms or will my doctor/hospital do that?
- May I use local physicians and hospitals or must I use those approved by the plan, even if I have to go to another community?
- Is my physician required to obtain permission from the plan before services are rendered?
- Will I be covered for urgent care if it is not rendered in a hospital associated with my health care plan?
- What happens if my physician ceases to be a participant in the plan while I am under his/her care?

Basic Health Care Plans

Fee-for-service is the traditional manner of receiving and paying for medical care. You choose your physician, hospital, and any other medical care you need. You are charged for the care you receive. Often, your care is paid for through a health insurance company whose premiums may be paid by employers. You may pay a deductible (an amount you must pay before your insurance company begins paying for your health care), or a co-payment (you pay a portion of the bill and the insurance company pays the balance).

Health Maintenance Organization (HMO)

An HMO is an organization that provides health care to a group of persons for a pre-determined price. An HMO offers broad coverage at a fixed price. The prepaid fee stays the same for a given period of time, usually one year regardless of the amount of health care used. That fee may be paid by you or, in full or in part by an employer, government or some other sponsor. In some HMOs, services are offered only at specific locations by groups of physicians and other health care personnel. You are required to use the HMO facility and staff to receive medical care.

Independent Practice Association (IPA)

An IPA is a type of HMO. Physicians practice in their office and care for both IPA subscribers and other patients. IPAs are formed by physicians who enter into agreements, usually with an employer group or insurance company, to provide medical services to that group's employees. Since the IPA is an HMO, the patient still must choose a particular group of physicians and a specific medical facility from which to receive medical services.

Preferred Provider Organization (PPO)

A PPO is a group of health care providers who agree to provide services to a specific group of patients (usually employment based groups) at an agreed upon rate.

A Word of Caution

Keep in mind that there are many different types of HMOs, PPOs, IPAs, and other insurance plans being offered today. Each of them has specific restrictions as to the type of care you receive, where you receive it and from whom. Before joining any plan, or before changing your current medical plan, learn as much as possible about the options being offered to you. Ask for written information which outlines the pluses and minuses of each option and read it carefully. Before you make a final decision, discuss the options with your personal physician to make certain that you will be able to receive the care you need under the option you choose.

Finally...

You should realize that many employers choose a plan for their employees. You may not have a choice. However, the information and questions contained in this article will, at the very least, make you more aware of your current health care plan.

Your physician is the best person to help you understand what's happening in medicine today. If you have questions about any subject mentioned here, we encourage you to ask your physician.

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VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed, caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.2% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol%, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J9VS61R2(819)

MSD
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VASOTEC is generally well tolerated and not characterized by certain undesirable effects associated with selected agents in other antihypertensive classes.

VASOTEC is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

A diminished antihypertensive effect toward the end of the dosing interval can occur in some patients.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

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***COVER:** Louisville, site of the KMA Annual Meeting, Sept 24-27, is a kaleidoscope of beauty and culture to enchant the visitor. At top, l to r, Hyatt Regency Hotel, Water Tower, Churchill Downs; center, Kentucky Derby Museum, J. B. Speed Art Museum; and bottom, Belle of Louisville steamboat, and the waterfront with the Louisville Falls Fountain in the foreground.*

Photos courtesy Louisville Convention & Visitors Bureau.

See page 360 for more information on your Annual Meeting.

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Your AMA Delegation

'This is a new feature we started this year, hoping to better inform you of the tremendous amount of information and policy making that is accomplished on your behalf at the AMA House.'

By now I hope you are all aware that your AMA Delegation is contributing regular articles to the *Journal.* This is a new feature we started this year, hoping to better inform you of the tremendous amount of information and policy making that is accomplished on your behalf at the AMA House. We meet in June for the Annual Meeting and in December for the Interim Meeting.

In December, we considered 187 resolutions and 79 Board and Council reports. In order to be better informed, the eight members of the Delegation are assigned a separate Reference Committee to study and attend, and then report back to the entire Delegation. We try to keep these Reference Committee assignments the same each meeting, since a lot of the same issues are discussed over and over at each meeting. We feel this is the most effective way to be informed and to best represent you.

My Reference Committee is Constitution and By-Laws. For the past several sessions of the House, many hours have been spent, both in Committee and on the House floor, debating who should be granted delegate status to the House of Delegates. Although there are guidelines concerning this matter, it appears to most of us that who gets in depends more on the whim of the House at that moment than on proper credentials. The Report of the Long-Range Planning and Development Council was referred back to them for better clarification on this issue. Since there are now 435 Delegates, there is much concern that the state societies are being diluted too much and are not fully represented.

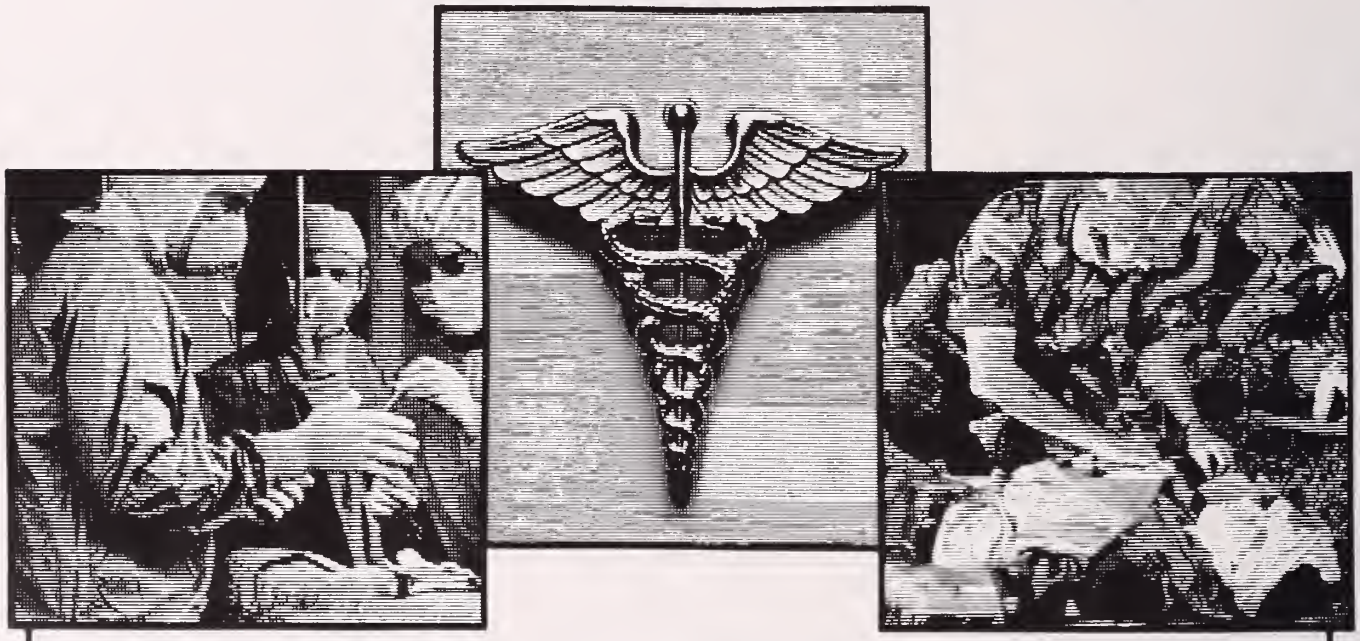
We also receive the reports of the Council on Ethical and Judicial Affairs. Although the House cannot alter their reports, they may refer them back to the Council for reworking. These reports usually generate much discussion also. In December, they submitted a report concerning the Fundamental Elements of the Patient-Physician Relationship. Essentially, this is a patient bill of rights. The House did not agree in principle with some elements of this report and it was referred back to the Council and will be reported on again in June.

Another interesting report was from the Board of Trustees on the Maternal Fetal Conflict. This was an excellent 16-page report, but the House felt that it was such a difficult subject that a little more refinement was needed; therefore, it was referred back to the Board for a new report at the Annual Meeting.

In closing, I would encourage each of you to read the *AMA News* that summarizes all the House actions that are taken at the Annual and Interim Meetings.

Donald C. Barton, MD
Senior Delegate to the AMA

GENERAL SURGERY TAKES ON NEW MEANING IN THE ARMY RESERVE.



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Upper Extremity Wound Management

Lorne E. Weeks, III, MD; Luis R. Scheker, MD

Many hand infections can produce permanent disability if not treated promptly and aggressively. Glass wounds and paint or grease gun injections can result in serious deep infections and often require immediate treatment in the operating room. The following common infections challenge the treating physician regarding their indications for surgical versus nonsurgical treatment. Caught early, infection of the nail fold (paronychia) responds to soaks in warm saline, oral antibiotics, and elevation of the affected part; in later stages, incision and drainage are necessary. Felons, subcutaneous abscess of a digit's distal pulp, must always be treated surgically, however. Herpetic whitlow, caused by herpes simplex, looks similar to other infections of the digit but pursues a self-limited course, resolving in 3 to 4 weeks; surgical treatment is strongly contraindicated. If erythema and drainage persist following proper treatment of hand infections, osteomyelitis should be ruled out with appropriate x-rays.

From the Christine M. Kleinert Institute for Hand and Micro Surgery, Louisville, KY, and the Division of Orthopaedic Surgery, University of Kentucky School of Medicine, Lexington, KY.

Upper extremity wound management encompasses a broad range of conditions from relatively simple, common infections to mutilating, Grade III, open injuries. This report is intended to summarize our experience with the more common hand infections likely to present to the clinician.

Introduction

Hand infections produce tremendous morbidity, affect persons of all ages, and can produce permanent disability if not treated promptly and aggressively. The diagnosis of hand infection must be made promptly. Within 24 to 36 hours of onset, high doses of systemic antibiotics and appropriate splinting can arrest some infections during their cellulitic or preabscess stage. After 24 hours, an unfortunate chain of events can occur (Fig 1). First, bacteria seed dead space and tissue with impaired circulation. Tissue reaction and edema produce further dead space, and the increased tissue tension aggravates an already impaired circulatory status. Ultimately, microvascular thrombosis and generalized ischemia followed by abscess formation result.[1] Early recognition and prompt, aggressive intervention are therefore crucial.

Any trauma is a violation of the integrity of the skin barrier. When this is associated with injury to underlying vessel, nerve, tendon, or bone, the potential for infection and increased morbidity is compounded. Regardless of the type of hand infection, one must always prophylax against tetanus, especially in tetanus-prone wounds, like those containing soil, animal, mouth, or fecal contamination.

The clinician must always remember that certain systemic diseases, such as diabetes mellitus, malignant states, and other forms of immunocompromise, are associated with a slower resolution of hand infections. These increase the likelihood of amputation, gram negative bacillary infections, and repeated surgical drainage and debridement.[2] Therefore, whenever the patient's

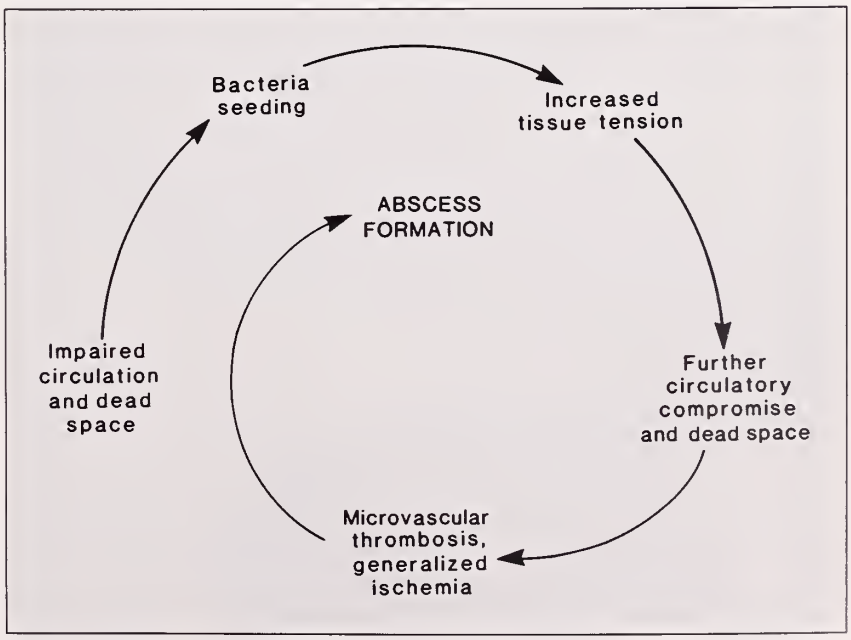

Fig 1 — Pathogenesis of abscess formation.

immunologic defenses are compromised, it is incumbent upon the physician to treat promptly and aggressively.

Many upper extremity infections may be treated early on in the office or the emergency room. Some wounds, such as those produced by glass or by paint or grease gun injection, may look relatively benign but are serious and extensive injuries requiring prompt treatment in the operating room by experienced hand surgeons. If left untreated, these are at risk for infection and significant morbidity, even amputation. In general, infections that must be treated in the operating room require aggressive, definitive drainage and excision of all necrotic tissue. This limits the spread of the infection and promotes hand function.

A recent study by Peacock et al[3] demonstrates that preventive antibiotics are not necessary in the primary outpatient treatment of open wounds of the hand when accompanied by debridement, irrigation, and rapid primary repair in an operating room environment. In the judgement of these authors, "good surgical care may be the most important factor in preventing infection and imperfect wound healing [and] the use of antibiotics should be reserved for more serious injuries or specifically identified infections."

One's differential diagnosis should always include aseptic inflammatory conditions that may mimic an infectious process. These include gout, osteoarthritis, noninfectious tenosynovitis, acute soft tissue calcification, myositis crepitans, tumors such as malignant melanoma and osteoid osteoma, and local tissue response to chemicals, proteins and foreign bodies.[1] The management of these conditions is different than that for most infectious processes.

Paronychia, felons, and herpetic whitlows are three common infections of the hand that challenge the treating physician regarding the indications for surgical versus nonsurgical treatment.

Paronychia

When bacteria are introduced by hangnail, sliver, manicure instrument, or tooth into the paronychial fold, a subcuticular abscess frequently develops (Fig 2). Housewives, kitchen help, and cleaning workers whose hands are regularly immersed in water are at particular risk.[4] Physical findings include redness of the skin on the side or base of the nail with localized tenderness. Paronychial infections may be either acute or chronic. When neglected, acute pyogenic paronychiae may

Fig 2 — A, erythema and swelling describe a subcuticular abscess of the paronychial and eponychial folds; B, intraoperative drainage of paronychia; and C, postoperatively, erythema and swelling have resolved with restoration of normal digital contours and absence of nail deformity.

become chronic. In addition, superinfection with fungus or yeast *(Candida albicans)* may compound the problem. This is often seen in the immunocompromised patient with diabetes or cancer. Acute paronychia is usually secondary to staphylococcal or streptococcal infection. Gram negatives (coliforms) are less frequently involved.

Treatment depends upon the stage at which the patient presents. In the early stages, soaks in warm saline, oral antibiotics, and elevation and rest of the affected part are usually sufficient.

In the later stages when abscess formation has occurred, incision and drainage are necessary. If the paronychial fold and adjacent part of the eponychium are involved, one quarter of the nail on the appropriate side is bluntly separated from the underlying nail bed, and the elevated portion of the nail is sharply removed. The scalpel blade should always be directed away from the nail bed to avoid scarring and ridge formation and away from the nail matrix to prevent later growth deformity. If nail elevation fails to provide adequate drainage, a radial incision in the nail fold may be necessary. Removal of all the nail leaves an exposed and sensitive nail bed and therefore is avoided unless the subungual abscess is so extensive that a floating nail has resulted. The wound may be packed open and a program of warm saline soaks begun.[5]

Felon

A felon is a subcutaneous abscess of the distal pulp of the finger or thumb (Fig 3). The infectious process originates between the fibrous septa of the distal pulp space and spreads either outward through skin, inward toward the distal phalanx, or laterally through the rest of the pulp. A felon is often but not always associated with an antecedent injury. Pain and swelling develop, rapidly producing a throbbing sensation. Often, digital vessels will be obliterated, and the entire tactile pulp may then slough. In essence, an anterior closed-space infection develops and expands, breaking down the fibrous septae of the pulp space. The infection can extend toward the distal phalanx, producing osteitis or osteomyelitis, or toward the skin, with a sinus or necrotic slough on the palmar surface. Complications of an untreated felon include sequestration of the distal phalanx, pyogenic arthritis of the distal interphalangeal joint, and flexor tenosynovitis from proximal extension of the infection.

Felons must always be treated surgically. Surgical approaches for incision and drainage

Fig 3 — A and B, swelling and erythema associated with a closed-space infection of the digital pulp represent the typical appearance of a felon.

Fig 4 — A, small vesicles characterize the early appearance of herpetic whitlow; B, vesicles begin to coalesce; C, bullae containing clear or turbid but nonpurulent fluid are surrounded by hemorrhagic areas; and D, later, lesions encrustate and desquamate, pursuing a self-limited course to resolution within 3 to 4 weeks.

must avoid injury to digital nerves and vessels, provide adequate drainage, and not leave a disabling scar. Our preferred approach is the midvolar longitudinal incision, safely between the radial and ulnar neurovascular bundles, proximal to the tactile pulp yet distal to the distal interphalangeal joint crease. Anatomic studies have shown that it is largely a matter of chance whether lateral incisions sever the digital nerves. Injured digital nerves can produce causalgic pain postoperatively. Whenever possible, abscesses should be drained through skin immediately overlying them rather than by incisions that traverse uninfected pulp tissue and are quickly narrowed by edema.[4]

Herpetic whitlow

Herpetic whitlows are caused by a herpes simplex infection and represent a lesion whose appearance and evolution are unfamiliar to many physicians (Fig 4). Unwarranted surgical intervention can compound the morbidity of what is essentially a benign, self-limited disease process. It is crucial to differentiate the pyogenic paronychia or felon from the herpetic whitlow. Therapy that is appropriately surgical for a bacterial process is contraindicated for a viral infection. Herpetic whitlows predilect medical and dental personnel, in particular, nurses, anesthesia personnel, endoscopists, dentists, dental hygienists, and respiratory therapists.[4]

Symptoms and signs include tingling, which yields to an intense, throbbing pain. Small vesicles appear early and coalesce to form bullae with clear or turbid but not purulent fluid. Occasionally, hemorrhagic areas form. These lesions later encrustate and desquamate, pursuing a self-limited course that resolves in 3 to 4 weeks. Incising this aseptic area is contraindicated because secondary bacterial infection can ensue with prolonged and disabling fingertip problems. Viremia and viral encephalitis have actually resulted from operative intervention. Topical antiviral agents in otherwise healthy patients have never been proven to be of benefit.[6]

Postoperative Follow-up

If drainage and debridement have been definitive, preoperative comfort levels should be restored postoperatively. All systemic signs and symptoms, such as fever and pain, should resolve. Erythema and drainage should subside completely. If the patient is diabetic, insulin requirements should return to pre-infection levels; otherwise, an occult infection should be suspected. Any sign or symptom of recrudescent infection may be an indication that initial treatment was incomplete. In this setting, osteomyelitis should always be ruled out by appropriate x-rays.

Conclusion

Although not life-threatening except in the immunocompromised patient, common hand infections can significantly impair hand function. If such infections go unchecked, even for a relatively short period of time, secondary changes and functional compromise may become irreversible. Prompt and aggressive intervention, appropriate for the stage of the lesion, represents the patient's best chance for restoration of pre-morbid function and comfort levels.

ACKNOWLEDGMENT: We would like to thank Drs Joseph E. Kutz, Thomas W. Wolff, Tsu-Min Tsai, and James M. Kleinert for inclusion of their patients in this article and Kell Julliard for his assistance in writing and editing the manuscript.

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A Study of Breast Cancer Screening: Laurel County

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Introduction

Breast cancer is one of the leading causes of death among American women, claiming nearly 40,000 lives every year.[1] The overall incidence of the disease is 89 per 100,000, rising from 57 per 100,000 in women 35 to 40 years old, to 300 per 100,000 in women over the age of 80.[2] Early detection of small breast cancers is one strategy that many physicians and patients believe will help limit breast cancer's claim on the lives of women.

Mammography is considered to be an important part of this strategy since the results of the Health Insurance Plan (HIP) of Greater New York were published in 1977.[3] This was a randomized controlled study of yearly mammography, physical examination, and patient self-breast examination. A statistically significant reduction in breast cancer mortality was found only in women aged 50 years or more. The Breast Cancer Detection Demonstration Project (BCDDP) was conducted to study the feasibility of screening large groups of women for breast cancer with physical examination and mammography.[4] It was not designed to test the value of mammography since there was no control group. Nevertheless, 35% of the cancers that were found in women aged 40 to 49 years were found by mammography alone.

The results of the HIP study and the BCDDP form the basis for the breast cancer screening recommendations of the American Cancer Society. These recommendations are that all women should: (1) perform breast self-examination on a monthly basis; (2) have a physician conduct a physical examination of the breasts every three years between the ages of 20 and 40 years and annually thereafter; and (3) have a mammogram for baseline purposes between the ages of 35 and 40 years, every one to two years between the ages of 40 and 50 years, and annually thereafter.[5] These recommendations are controversial, and the use of mammography is one of the most actively debated issues in the medical literature.[6] The purpose of this study was to determine the role that family physicians play in helping to implement these recommendations in a rural Kentucky county. Other factors that might affect the implementation of these recommendations were also evaluated.

Methods

One of the authors (MF) worked in a surgical practice in a rural Kentucky county as part of a 10-week elective, "Medical Education and Community Orientation" (MECO). The MECO elective is designed to give rising sophomore medical students experience in both clinical and community medicine. As part of the elective, each student is to conduct a community oriented health care project.

In this project all women aged 35 years or more who presented to a general surgical practice were verbally asked the following questions: 1. Do you conduct a breast self-exam monthly? 2. Do you have a breast exam done by your family doctor on a yearly basis? 3. Has your family doctor ever advised you to have a mammogram? 4. Have you ever had a mammogram? 5. Do you have a mammogram on a yearly basis? 6. Does the cost of a mammogram exam discourage you from having one done? Responses were recorded by the medical student on a standard form. Office records were used to determine the patient's age, employment status, marital status, type of health insurance, and whether the patient had any history of breast cancer or related symptoms. Fifty women met these criteria and were invited to participate in the study.

A chi-square test of independence was used to test the null hypotheses of no relationship between the variables under study and demographic characteristics. An alpha level was set at .05 for all analyses ($p \leq .05$).

Results

All of the 50 women who met study criteria agreed to participate in the survey for a response rate of 100%. Twenty-one (42%) practiced monthly

breast self-examination and 34 (68%) stated that they received a clinical breast examination by their family physician on a yearly basis. Twenty-seven (54%) had been advised by their family physician to have a mammogram performed. Twenty-eight (56%) had a mammogram performed in the past, although 12 (24%) did so on an annual basis.

The average age of this group of women was 54.3 years with a range of 35 to 81. Ten were aged 35 to 39 years; 10 aged 40 to 49 years; 9 aged 50 to 59 years; and 21 were over the age of 60. Three were single, 20 married, 8 divorced and 10 widowed. Twenty-one (42%) of these women were employed and 40 (80%) were covered by medical insurance. Thirteen (26%) had a history of breast cancer or related symptoms.

The chi-square analysis revealed that having a physician conduct a yearly breast examination was related to having been advised to have a mammogram ($p \leq .05$). A significant relationship was also found between items that addressed whether or not patients had been advised to have a mammogram and whether or not they should have a mammogram on a yearly basis ($p \leq 0.05$). Relationships were also found between items two (yearly breast exam by a physician) and five (yearly mammogram) as well as between question two and a positive history of breast cancer or related symptoms ($p \leq 0.01$).

Significant relationships were also found between having been advised to have a mammogram by a family doctor and having had a mammogram ($p \leq .001$). Women who had been advised to have a mammogram by their family doctors were not only five times more likely to have a mammogram done, but were also more likely to have one on a yearly basis ($p \leq 0.001$). No other pairs of questions and/or demographic factors were found to be significantly related.

When the pattern of responses to the screening items were studied, it was found that these women tended to be extreme in their behavior. That is, 10 women answered "no" to all of these questions, whereas 12 answered "yes." Therefore, 22 (44%) exhibited an "all or none" behavior pattern toward breast cancer screening.

Of the 28 women who received a mammogram, 24 had been advised to do so by their family physicians. Of the 27 women who were advised by their family physicians to obtain a mammogram, only three did not do so. Cost was listed as a factor by only one of these three women.

Only seven (14%) stated that cost discourages them from having a mammogram performed. Of those seven women, five were advised by their family physicians to have mammography performed and four of them actually did obtain a mammogram.

Discussion

Norman and Tudiver concluded that explicit instruction by physicians in breast examination was positively related to the frequency with which women perform breast self-examination.[7] Likewise, this study found that obtaining a mammogram was positively related to having annual physician breast examinations and to having been advised to obtain a mammogram by one's family physician. Although this may not come as a surprise to many family physicians, it should emphasize the importance of the family practitioner's recommendations. Many women will obtain mammograms if their physicians advise them to do so. This is especially important when one considers that 46% of the women in this survey had not been advised by their family physician to obtain a mammogram. This survey suggests that most of these women would have a mammogram if advised to do so by their family physician.

The cost of mammography did not seem to be an important consideration for the women in this survey. For those few for which cost was a consideration, physician recommendation seemed to mitigate this concern.

ACKNOWLEDGEMENTS: The authors wish to thank Drs Alan D. Graham and James M. Stern of London, Kentucky for their help with this work, and Dr Cheryl Aspy for assistance in manuscript preparation.

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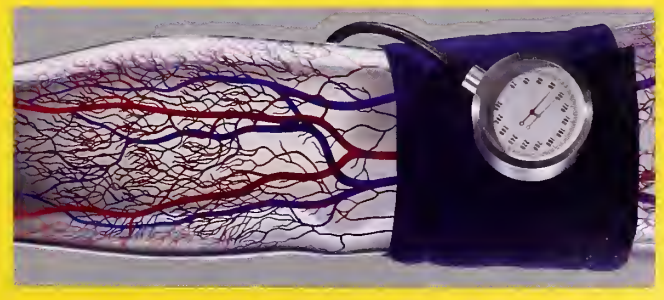

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Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence. 12/21/89 • P90-W198V

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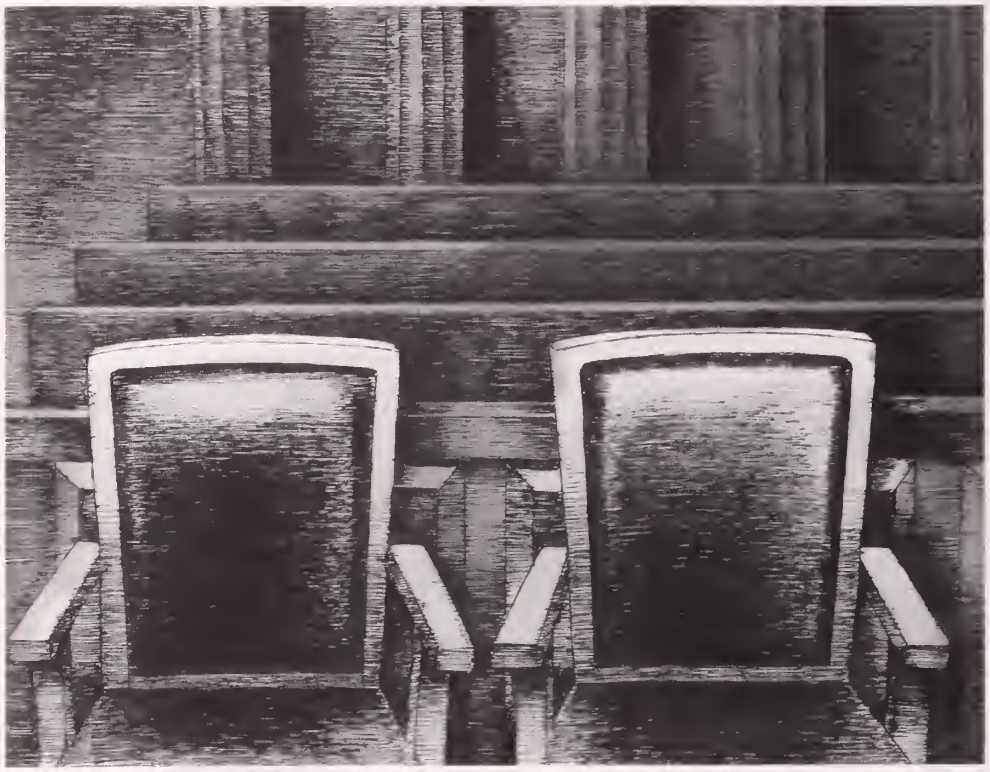

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Tennis Elbow

Ronald C. Burgess, MD

The term "tennis elbow" has been used in the medical literature for over 100 years to describe a variety of conditions on the lateral aspect of the elbow. Recent writers seem to agree that the two most common causes for this condition, which may be either distinct or coexisting, are lateral epicondylitis and radial tunnel syndrome. Lateral epicondylitis is not limited to tennis players; 95% of the reported cases occur in non-players. The presenting symptoms are pain over the origin of the extensor carpi radialis brevis and weakness in the wrist and digital extensors. The location of maximal tenderness differentiates lateral epicondylitis from other conditions. A variety of treatments has been suggested, but the most successful is conservative treatment with rest, restriction of lifting with the palms down, anti-inflammatories, and local applications of ice. Once the acute inflammatory phase has passed, a flexibility and strengthening program is recommended. Steroid injection may be utilized at this stage if the discomfort has not been reduced. In a small percentage of cases, surgery may be required.

From the Department of Surgery, University of Kentucky, Lexington, KY 40536. Dr Burgess is Assistant Professor, Chief, Section of Hand Surgery.

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"Tennis Elbow" is a term which has been used in the past to describe a variable number of conditions on the lateral aspect of the elbow. Tenderness and mild discomfort on this aspect of the elbow are frequently seen in the average population beyond middle age. In the majority of people this condition does not require the attention of a physician, although the examination of a patient for other conditions will often reveal tenderness to palpation in the area. At other times the lesion will become significantly painful, either following repetitive strain or a single activity, and treatment will be required.

The term "tennis elbow" first appeared in 1882, as a description of a painful condition seen in English lawn tennis players.[1] The original description was actually for pain on the medial aspect of the elbow which was felt to be secondary to a sprain of the pronator teres muscle. Controversy as to the etiology of this condition began within the year in the *British Medical Journal*, with several authors claiming a neurologic cause for the condition.[2,3,4] The debate as to the exact etiology of the lesion on the lateral aspect of the elbow has continued through the past 100+ years. Every structure on the lateral aspect of the elbow has been described as the cause at some time. The three most popular theories in the English literature have been proposed by Cyriax, Kaplin, and Bosworth. Cyriax felt that a tear in the origin of the extensor carpi radialis brevis was the source of pain.[5] Kaplin, in 1959, felt that an irritation of the periarticular branches of the radial nerve caused the symptomatology.[6] Bosworth felt that the orbicular ligament impinged on the radial head and that this was the etiology of the syndrome.[7] An extensive and detailed investigation into the cause of lateral elbow pain by Goldie in 1964 established a degenerative tear of the attachment of the extensor carpi radialis brevis to the distal aspect of the lateral epicondyle as the primary etiology of tennis elbow.[8] This tear was found to be filled with a highly vascular granulation tissue which was felt to be pathognomonic for the condition. These findings have been confirmed by Nirschl and Coonrad.[9,10] Lateral epicondylitis is the preferred name for this condition.

The proponents of a neurologic etiology for tennis elbow have found support in a separate, distinct syndrome, the radial tunnel syndrome.[11,12] In this syndrome the deep branch of the radial nerve is compressed as it dives between the two heads of the supinator muscle. This is felt to be an entity separate from lateral epicondylitis, although coexistence of the two conditions has been found.[13]

Occurrence

Lateral epicondylitis occurs equally in men and women and is most common in the fourth decade.[5,14] It is primarily limited to Caucasians and is considered rare in black persons.[10] Although anywhere from 10% to 50% of people who regularly play tennis will exhibit symptoms of lateral epicondylitis, 95% of the reported cases occur in people other than tennis players.[10] Work

or play which requires repeated pronation and supination or lifting with the hands in the palm down position are felt to be predisposing factors for this syndrome.[5, 9, 10]

Presenting Symptoms

The patient presents with complaints of lateral elbow pain and a feeling of weakness of the wrist and digital extensors. The onset of symptoms can be sudden or gradual with a history of repetitive overuse. In many cases no predisposing conditions can be found. The pain is described as a "burning" pain and is often described as radiating down the forearm.

On physical examination the area of greatest tenderness is characteristically over the origin of the extensor carpi radialis brevis, which is on the distal anterior aspect of the lateral epicondyle (Fig 1).[14, 15] This area can best be palpated by flexing the elbow and palpating just distal to the lateral epicondyle. Resisted wrist extension with the forearm in pronation reproduces the pain at the lateral aspect of the elbow.[5, 14, 15] Passive flexion of the wrist with the elbow in the fully extended and fully pronated position also reproduces the patient's pain. The "coffee cup test," which is pain localized at the lateral epicondyle origin of the extensor brevis muscle with picking up a full cup of coffee, has been described as almost pathognomonic.[14]

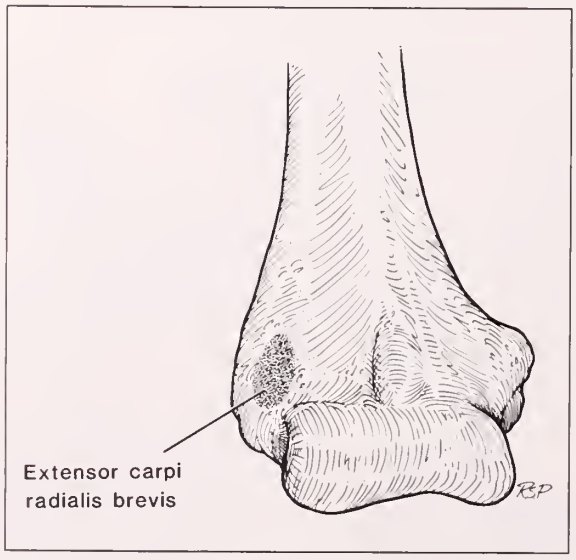

Fig 1 — The origin of the extensor carpi radialis brevis is on the distal slope of the lateral epicondyle. This is the area of greatest tenderness in lateral epicondylitis.

Additional Studies

X-ray studies are felt to be of little help in the diagnosis of tennis elbow. Calcification to some degree has been reported in 22% of patients in one series of cases.[16] EMG and nerve conduction studies are not helpful in differentiating impingement of the deep branch of the radial nerve from lateral epicondylitis, since these tests are usually negative in both conditions.[11, 12] Thermography may be of help in questionable cases.[17]

Differential Diagnosis

The primary condition to be differentiated from lateral epicondylitis is impingement of the deep branch of the radial nerve as it enters the supinator muscle.[11, 12] The two can be differentiated by the location of maximal tenderness. If the area of maximal tenderness is distal to the radial head, the clinician should suspect a radial nerve impingement as the etiology of the condition.[12] The area of maximal tenderness in lateral epicondylitis is within 1-2 centimeters of the lateral epicondyle.[14, 15]

The other condition to be differentiated is degenerative arthritis of the elbow joint. The pain in this condition is more diffuse and not localized to the lateral aspect of the elbow. The major symptom is often loss of motion.[18] The intense burning pain characteristic of tennis elbow would not be present with degenerative arthritis.

A radiculopathy from a lesion at the cervical foramen has also been described as the cause of lateral elbow pain; however, in this condition there will be painful restriction of neck motion but no point tenderness of the elbow.[14]

Natural History

Lateral epicondylitis has classically been felt to be a self-limiting condition. Cyriax said that the condition usually cleared in 8 to 12 months without any treatment; however, he did notice occasional cases which lasted much longer.[5] No study exists which shows what happens if tennis elbow is left untreated; all studies determine the results of some type of treatment.

Conservative Treatment

The treatment for lateral epicondylitis is controversial, with a variety of treatment regimens. The British have long used manipulation as a method of treatment. Both Cyriax and Mills described forceful adduction of the elbow in the fully extended position and described a loud "snap or pop" accompanying the manipulation.[5, 19] Theoretically this forceful maneuver is completing a partial tear of the extensor carpi radialis brevis tendon. Although this treatment has remained popular in Great Britain, it has found little popularity in the United States.

Multiple physical therapy modalities have been proposed as useful in the treatment of lateral epicondylitis. DMSO,[20] ultrasound,[21] laser,[22] and pulsed electrical fields[23] have not been shown to be of benefit in controlled studies. A forearm compression band which circumferentially compresses the proximal forearm has been utilized with success for tennis elbow in the mildly inflamed condition.[24]

The most controversial treatment for lateral epicondylitis is the installation of a steroid preparation into the area of maximal tenderness. The proponents of this treatment cite a high success rate with an initial injection and feel that by itself a steroid injection can be the definitive treatment for this condition.[25, 26, 27]Steroid injection certainly has the attraction of being a procedure by which a physician can dramatically alter the course of the syndrome. Other authors have stated that steroid injection, while effective in an acute situation, has a recurrence rate as high as 50%.[14, 28, 29] A steroid injection has also not been shown to have a higher success rate than treatment with an oral anti-inflammatory medication.[30, 31]

A balanced approach to the treatment of tennis elbow has been espoused by Coonrad and Nirschl and is felt to be the most successful way to eradicate the symptoms of lateral epicondylitis.[14, 15] With this program the initial treatment is rest from the offending activity, with particular emphasis on restricting lifting with the arms in the palms down position. During this period of rest, anti-inflammatories such as aspirin can also be utilized. Local applications of ice can decrease the local inflammatory reaction and be of benefit. Once the acute inflammatory phase has passed, progression to a flexibility and strengthening program should begin. Steroid injection into the area of maximal tenderness can be utilized at this stage if rest and oral anti-inflammatories have failed to reduce the level of discomfort. This is best done by the method of Hohl,[32] with an initial injection of local anesthesia into the area of maximal tenderness until all tenderness disappears. Immediately following this, and utilizing the same needle, a steroid preparation is instilled at a dosage of 10-15 milligrams into the area previously anesthetized. The patient should be forewarned that a moderate to severe increase in pain which may last from 10 to 15 hours may occur following steroid injection and should be treated with analgesics and local applications of ice. The injection may be repeated after 2 weeks if the discomfort reoccurs, although the number of injections should be limited to two to three since the local deposition of cortisone into a tendon can cause attritional ruptures.

Once the initial pain is relieved, a rehabilitation program to improve strength and flexibility in the wrist, elbow, and shoulder of the affected limb is begun. It is important that the rehabilitation exercises not be limited to the elbow but include the entire upper extremity. An excellent rehabilitation program for athletes has been detailed by Nirschl.[15] The exercise program is simple and not particularly time consuming. The program consists of four components.

1. An isometric exercise program for the forearm extensors.
   a. The first exercise requires the elbow to be fully extended and the arm in the fully pronated position.
      The wrist and fingers are maximally dorsiflexed for a count of 10 seconds. This should be done repetitively, working up to 30 repetitions per day (Fig 2).

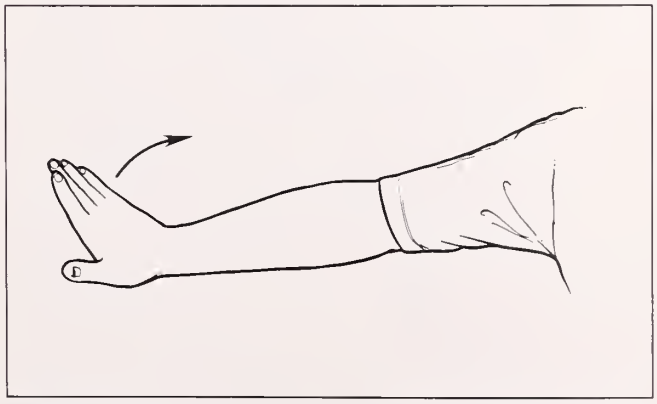

Fig 2 — Isometric exercises of the wrist and finger extensors should be done for a count of 10 seconds.

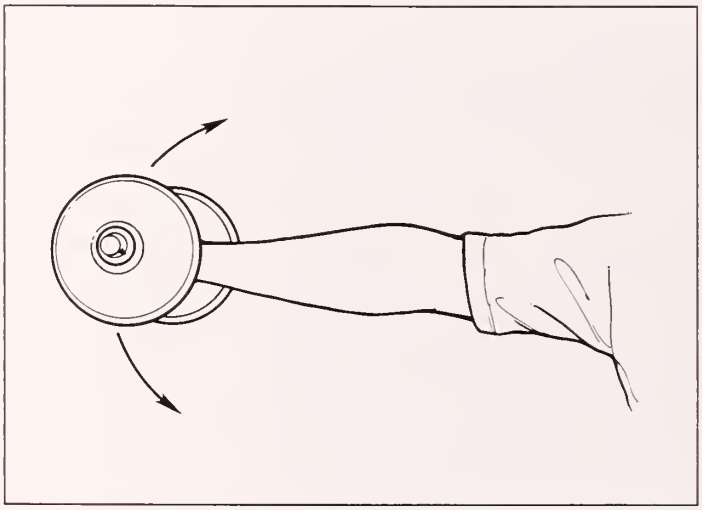

Fig 3 — Wrist extension curls are done with the shoulder in abduction.

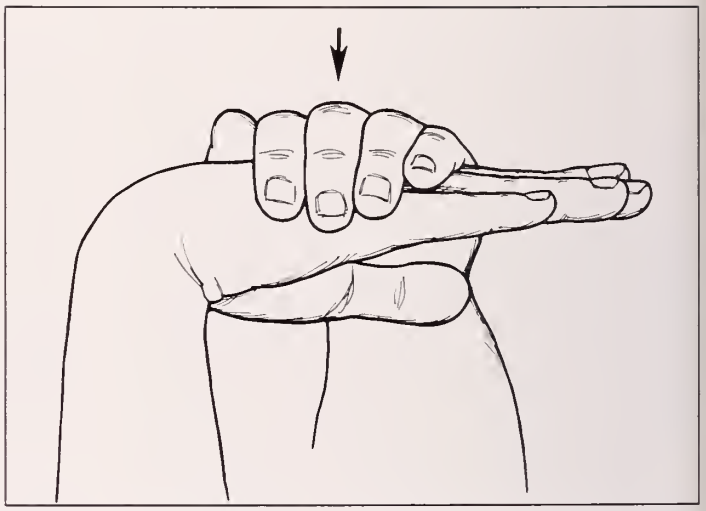

Fig 5 — Passive stretching of the affected muscle decreases the likelihood of further injury.

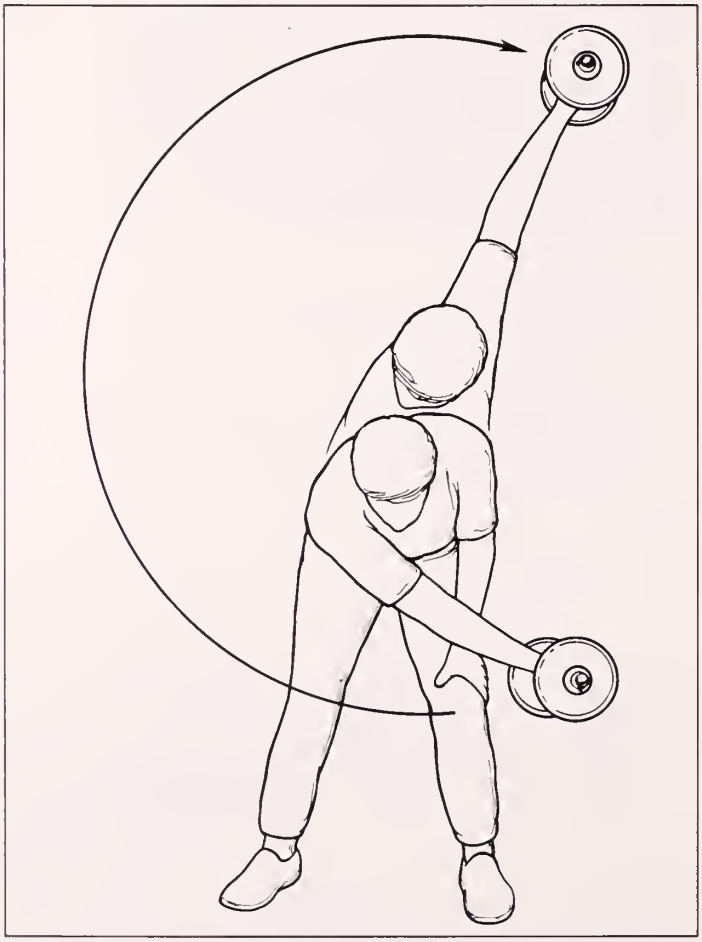

Fig 4 — Pendulum exercises stretch the entire upper extremity.

b. A tennis ball should be squeezed and held for a count of 15 seconds as many times per day as feasible.

2. Weight lifting exercises utilizing a dumbbell.
   a. Forearm extension curls with a 3 to 5 pound weight should be performed with the arm in abduction and held for a count of 10 seconds, working up to a maximum of 20 repetitions per day (Fig 3).
   b. A weight lifting military press, starting with 5 pounds and progressing to 20 pounds with a goal of 40 repetitions with the maximum weight and 40 repetitions at half maximum weight, is also recommended.
3. Flexibility exercises for the shoulder and forearm by means of pendulum exercises with a 5 pound weight (Fig 4).
4. Passive stretching of the wrist by holding the elbow in full extension with the forearm in full pronation and using the opposite hand to maximally flex the wrist. This should be done for a count of 10 seconds, 15 times daily, with a goal of obtaining 90 degrees of flexion (Fig 5).

This exercise program should be carried out under supervision, since an unsupervised and overly zealous patient can cause additional injury.

Surgical Treatment

In a small percentage of cases the pain is resistant to all conservative treatment, and surgical intervention is required. A variety of surgical treatments have been proposed for lateral epicondylitis. Each has demonstrated good results as reported by the originator of the procedure, including Runge who cured epicondylitis in 1873 by deep cauterization.[33] The majority of the surgical treatments have been based on the author's concept of the etiology of the condition. Bosworth, who felt that the orbicular ligament of the radial head was responsible for the condition, had excellent results with excision of part of the extensor origin as well as excision of the orbicular ligament.[34] Kaplin, who felt that peripheral nerve irritation was the etiology of the condition, treated tennis elbow successfully by denervation.[6] Garden, who felt that the origin of the extensor carpi radialis brevis was the etiology of the condition, treated it by distal tendon lengthening of the affected muscle.[35] Other authors also reported good results with total release of the extensor musculature from the lateral epicondyle or with extensor fasciotomies.[25, 36, 37, 38]

The most popular surgical procedure in recent years is limited excision of the abnormal tissue from the extensor carpi radialis brevis tendon while leaving the surrounded unaffected structures intact. This procedure has the advantage of treating only the pathologic area. The surgical procedure, which has been outlined by Coonrad[10] and Nirschl,[9] involves elevation of the extensor carpi radialis longus tendon off the origin of the brevis and excision of the abnormal granulation tissue. Both authors either remove the portion of the lateral epicondyle under the area of irritation or drill it with multiple drill holes to provide greater vascularity in the repair area. This procedure has shown excellent results in both authors' hands.

Conclusion

Tennis elbow (lateral epicondylitis) is a common condition primarily affecting people in the fourth or fifth decade of life. Conservative treatment with the use of rest, anti-inflammatories, and a progressive rehabilitation program will eliminate the problem in the majority of cases. Cortisone injection and surgical treatment are useful in cases which fail to respond to conservative treatment.

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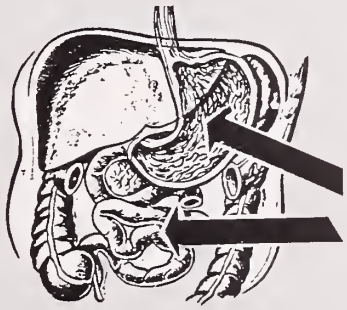

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Editorials

'Hospital charges today are truly incredible. They must average 30 times (or more) what they were in 1955. . . . I'm amazed that there are not organized mechanisms in place for reviewing the appropriateness of hospital charges.'

It's my turn to write an editorial this month and I really don't have anything I want to write about. I've already written about windows, deploring the absence or paucity thereof in various hospital work places and patient care areas. I've already written about sidewalks, deploring the absence thereof in most subdivisions developed since World War II. Since I have no favorite subject to address, I decided to forego the pleasure and just not have an editorial in the *Journal* this month. When this decision became known to our intrepid editor in chief, he threatened me with severe and painful bodily harm if I failed to produce. Stimulated by this threat, I have taken pen in hand and am wandering aimlessly down this page.

When I look at the practice of medicine today, I can't help but compare things with the way they were in 1955 when I entered practice. The differences are astounding, but they occurred rather gradually (actually, much faster than ever before). I have reminisced about some of those changes in a previous editorial and will not bore you by repeating them. The one transition of which I have become increasingly aware is the escalation of hospital charges. Hospital charges today are truly incredible. They must average 30 times (or more) what they were in 1955. Much of this can be explained by rising labor costs, expensive new technologies, etc, etc, but it's still difficult to comprehend. When I hear of the multi-thousand-dollar hospital bills for some relatively brief outpatient surgical procedures, I just can't believe it. We have all heard about huge charges to hospitalized patients for some simple medications such as two aspirin. How can that be fair?

Maybe there is justification for all this. Maybe I'm incorrect in thinking there's something wrong. Maybe my impression that some hospitals are much worse than others in this regard is inaccurate. Maybe so, but I doubt it. I'm amazed that there are not organized mechanisms in place for reviewing the appropriateness of hospital charges. It's something to think about.

McHenry S. Brewer, MD

JULY

18-20 — "Development and Plasticity of the Spinal Cord" sponsored by Ohio State University's Center for Continuing Medical Education, the National Institutes of Health, the National Science Foundation and The Bowman Gray School of Medicine of Wake Forest University, at the Novice G. Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus, Ohio. The program meets the criteria for Category I of the Physician's Recognition Award of the AMA. Contact: Ohio State's Center for Continuing Medical Education, (800) 492-4445 or (614) 292-4985.

AUGUST

3-4 — "Management Of Post-Surgical And Post-Traumatic Complications In Orthopaedics" — Ritz-Carlton Hotel, St Louis, MO. Sponsored by Washington University School of Medicine. Program Chairman: Clayton R. Perry, MD. AMA Category I approved — hours to be determined. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St Louis, MO 63110; (800) 325-9862, (314) 362-6893.

8-12 — 3rd Annual Meeting of the Southern Association for Oncology, Orlando, FL. Contact: Kathy McLendon, Communications & Marketing Assistant, Southern Medical Assn, PO Box 190088, Birmingham, AL 35219-0088, (205) 945-1840.

18-25 — "Comprehensive Review in Internal Medicine" Conference; Hyatt on Capitol Square, 75 E State St, Columbus, Ohio. Sponsored by The Ohio State University Hospitals Department of Internal Medicine. Fees: $750 for the full week if registered before June 15; participants must register for a minimum of four days at $550. Approved for 77.5 Category I Continuing Medical Education credit hours. Contact: Ohio State's Internal Medicine Department — (800) 752-8606.

SEPTEMBER

22 — "Ophthalmic Insights into the 90s." Presented by N. D. Radtke, MD and Humana Hospital Audubon. The conference qualifies for 3.5 hours in Category I of the AMA Physicians Recognition Award. Contact: N. D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217, (502)636-2823.

28-29 — Fifth Annual Multispecialty Oculoplastic Surgery Symposium. A cojoint symposium by all specialties involved with the management of problems of the midface and ocular adnexa to discuss the state of the art solutions to the difficult situations in the realm of oculoplastic surgery. Contact: Karen Heidorn, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 North Eagle Creek Drive, Lexington, KY 40509, (606) 268-3754.

OCTOBER

14-17 — Southern Medical Association's 84th Annual Scientific Assembly, The Opryland Hotel, Nashville, TN. Contact: Kathy McLendon, Communications & Marketing Assistant, SMA, PO Box 190088, Birmingham, AL 35219-0088, (205) 945-1840.

NOVEMBER

1-3 — "Clinical Allergy for the Practicing Physician" — Sponsored by Washington University School of Medicine. Program Chairman: Phillip E. Korenblat, MD. AMA Category I approved — hours to be determined. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

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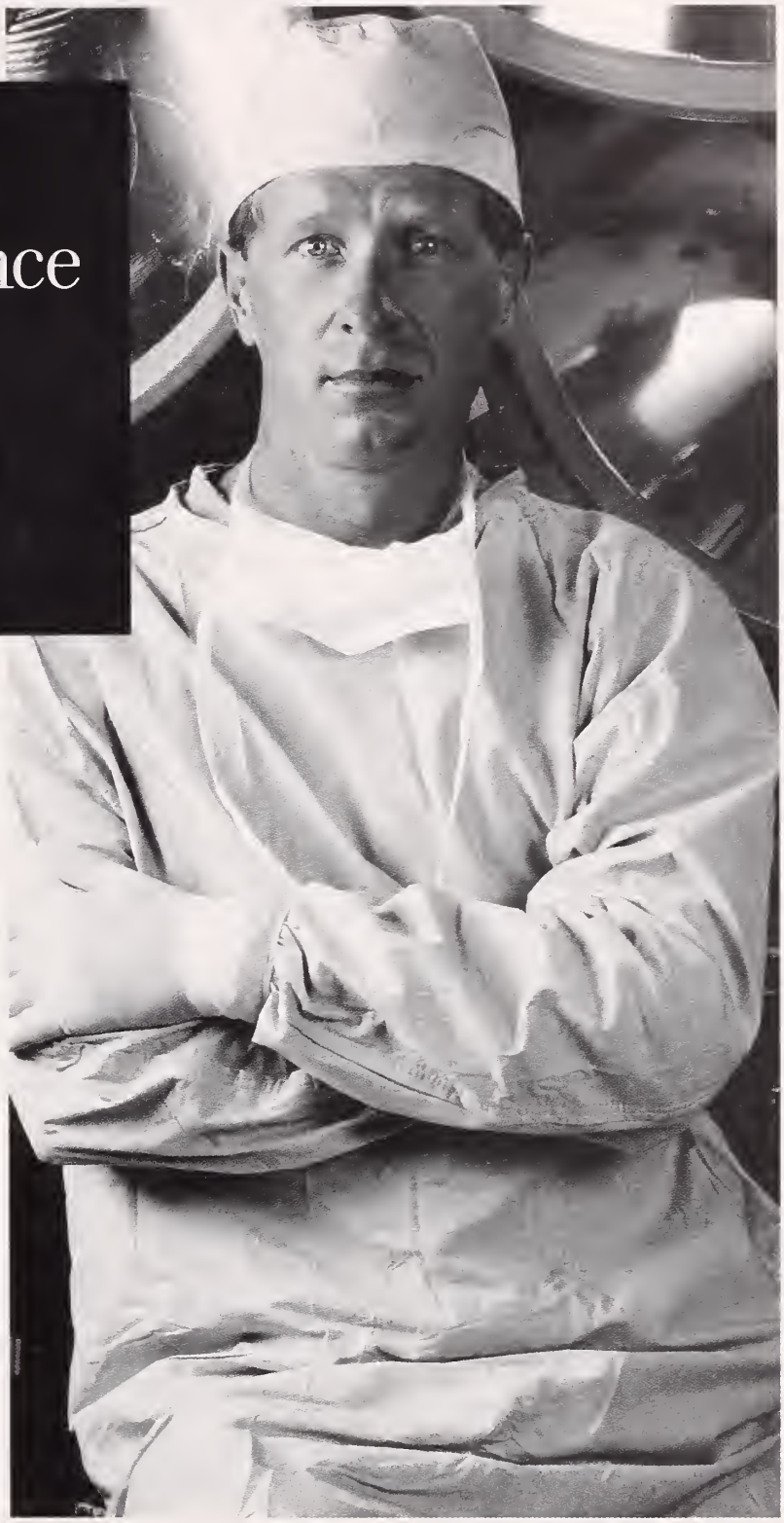

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Convention Center and Hotel

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Louisville is an ideal convention city and ranks among the country's top ten cities in convention attendance. At the same time, it ranks the lowest in food and lodging costs.

It is important that you begin to make your room reservations as soon as possible for the meeting September 24-27. The Hyatt Regency Hotel will be the headquarters hotel, (502) 587-3434. In making reservations, **please be sure** that you indicate you are attending the Kentucky Medical Association Annual Meeting to receive a **special convention rate:** single $65 and double $75.

Shopping and Sightseeing

Downtown Louisville offers a wealth of things to see and do. A few blocks from the Hyatt Regency Hotel and Convention Center is the Museum of History and Science with exhibits of modern technology and ancient history. On display is the Appollo 13 space capsule along with a 2600 year old mummy, and the IMAX theatre that combines a huge image on a 4-story tall screen with a 27 speaker surround sound system. The IMAX theatre system is the only one of its kind in Kentucky, Indiana, and Tennessee. In September, there will be four different films showing in rotation (you can be blasted into outer

space in the space shuttle; go inside the human heart; hover above the surface of the earth; or walk on the ocean's floor). Close to the museum is the Kentucky Art and Craft Gallery featuring works by Kentucky artists.

The hotel and Commonwealth Convention Center, in renovated downtown Louisville, are both ideally located to take advantage of sightseeing, shopping, and dining.

The Gallery has jewelry, pottery, sculptures, and folk art and crafts on display and for sale. One of Louisville's newest attractions is the Louisville Falls Fountain which will be in operation during the meeting. Other downtown attractions include the Kentucky Center for the Arts, Actors Theatre of Louisville, lunch or dinner cruises on the Ohio river aboard the Star of Louisville, the McCauley Theatre, and Louisville Gardens.

Within walking distance is downtown Louisville's historic district with classic architecture that brings history to life. The 19th-century stone and cast-iron buildings on West Main Street are the largest collection in the U.S. outside of New York City. Elegantly crafted storefronts provide a beautiful complement to new office towers and the modern Kentucky Center for the Arts.

Discover the grace of the Victorian era in Old Louisville, the city's first suburb. Developed in the late 19th century, during the period of prosperity that Louisville enjoyed after the Civil War, old Louisville contains a spectrum of architectural styles. A short drive from downtown Louisville is some of the finest 19th century residential Victorian architecture in the country. The breathtaking display of homes in Belgravia Court and St. James Court, which offer turrets, gargoyles and other imposing ornamental designs, will keep you fascinated for hours. Also in Old Louisville are the Conrad House, dating from 1895, and the Brennan House, an opulently furnished, beautifully preserved Victorian townhouse.

Parking and Transportation

Parking is hassle free in downtown Louisville. The hotel offers enclosed parking for 650 cars with additional parking available across the street and connected to the Convention Center by a walkway. There are ten additional CITYPARK garages conveniently located throughout the downtown area. Colorful CITYPARK banners on the garages will tell you where to park. For a fun and fast way to get around downtown, the Toonerville II Trolley is available **free of charge.** Each of the nine trolleys is a detailed reproduction of streetcars used during the turn of the century that feature mahogany seats and woodwork, along with gleaming brass hardware. The historic theme is carried out along the trolley route with authentically styled benches, planters and street lamps. Its 2.5 mile route links the Broadway area to the south end of the business district with the waterfront area at the north end.

Parking is hassle free in downtown Louisville. The hotel offers enclosed parking for 650 cars with additional parking available across the street and connected to the Convention Center by a walkway.

If the weather gets bad, use the Skyways in downtown Louisville. These are easy indoor connections between hotels, parking garages, the Convention Center, the Galleria, and Starks Court. *kma*

Rural Kentucky Medical Scholarship Fund Applications

Donald R. Stephens, MD, RKMSF President, presented a plaque to retiring President Carolyn H. McKinley, MD.

Retiring U of L representative James C. Moore, MD, was recognized for his service. Dr McKinley made the presentation.

The Board of Directors of the Rural Kentucky Medical Scholarship Fund, Inc held its annual meeting on May 17, 1990, at KMA Headquarters. The first meeting of the Fund was held in Louisville on December 12, 1945. It was organized jointly by the Kentucky Medical Association and the University of Louisville School of Medicine for the purpose of supplying physicians to rural areas. A Board of Trustees was appointed, and C. C. Howard, MD, Glasgow, served as the first Chairman until his death in 1971.

Carolyn H. McKinley, MD, daughter of C. C. Howard, MD, recently retired as President of the Fund. A plaque was presented to her in recognition of her faithful and loyal service and continuing support of the Fund's programs. Donald R. Stephens, MD, Cynthiana, a past recipient, presented the plaque, and will serve as the new President of the Fund.

In absentia, a plaque was presented to Mr Gilbert L. Armstrong, who has retired. At one time, Mr Armstrong was Executive Secretary of the Fund, and he has continued to offer his services as a member of the Executive Committee and the Board of Directors.

James C. Moore, MD, who retired, was presented a plaque in recognition and appreciation for his contributions to the Fund as a representative of the University of Louisville School of Medicine. Michael Foster, MD, was elected to represent U of L.

The following were elected as new members of the Board: John Watts, MD, Bedford; A. H. Joslin, MD, Owensboro; Michael Foster, MD, Louisville; John A. Logan, MD, Henderson; John Rawls, PhD, Lexington.

For the school term 1990-91, the RKMSF loans will be in the amount of $10,000, and the interest rate will be 5%. Eleven new applicants were approved for loans; 8 of these will be attending the University of Kentucky Medical College and 3 will be attending the University of Louisville School of Medicine. Eleven renewal requests were approved. Five recipients will be entering primary care residency programs. One of the 5, William Scott Black, is participating in an accelerated residency program at the University of Kentucky in which his fourth year of medical school was combined with the first year of Family Practice residency. Eight recipients are in specialty training, and 8 will be entering practice in September. Eight recipients received forgiveness for practicing in critical counties. Twelve physicians completed their financial and/or practice obligations in 1989-90.

The Board was informed of the success of the RKMSF Establish Practice Grant Program. Upon completion of a year of practice in a critical county, each physician participating will receive a $10,000 grant to defray his educational debt. This grant is renewable for a period of 4 years. Jerry Jamieson, MD, is practicing in Russell County; Gary Partin, MD, is practicing in Adair County; Dennis Campbell, MD, is practicing in Knott County; Matthew Stiles, MD, upon completion of his residency training, will begin practicing in Menifee County in July.

As in the past, the Fund's success has been based on the dedication of the members of the Board of Directors and the continued assistance and support of the Kentucky Medical Association. *kma*

20th Annual Emergency Medical Care Seminar

The 20th Annual Emergency Medical Care Seminar was held at Lake Barkley State Resort Park this year and offered a variety of topics from "Trauma Injuries" to "Gunshot Wounds" and "Alcohol and Substance Abuse." During this year's program the Board of Trustees presented awards to E. Truman Mays, MD, Chairman of the Committee, for his 20 years of service, and to Cheryl Westbay, RN, for her help in planning the programs. Guest speakers during the program included Ardis D. Hoven, MD, Lexington, and Charles R. Oberst, MD, Louisville. This was the last year that the program will be sponsored by the Kentucky Medical Association. Next year the program will be sponsored by the Emergency Nurses Association and will be held at Lake Barkley in September. *kma*

Ardis D. Hoven, MD, Lexington, presented a plaque to E. Truman Mays, MD, Chairman of the EMCS Committee, for his 20 years of service (top, left). Cheryl Westbay, RN, was the recipient of a plaque in recognition of her many years of assistance in planning the program. Dr Hoven is pictured with Ms Westbay (left). Charles R. Oberst, MD, a Louisville OB-GYN, was one of the guest speakers (above).

Board of Trustees Spring Meeting

AMA Senior Delegate Donald C. Barton, MD, presented a report to the Board. Chairman William C. Monnig, MD, presided at the head of the table.

AKMA President Esther Jansing reported on Auxiliary accomplishments during the past year.

A bound volume of the 1989 Journal was presented to Editor A. Evan Overstreet, MD, by KMA President Nelson B. Rue, MD.

The KMA Board of Trustees met on April 18-19, 1990, at the KMA Headquarters Office in Louisville.

The Board members heard reports from the President; the President of the Auxiliary to KMA; the Senior Delegate to AMA; the President of the Board of Medical Licensure; the Dean of the University of Kentucky; the Vice Chairman of the Board of KMIC; and the Commissioner of the Bureau for Health Services.

Secretary-Treasurer, S. Randolph Scheen, MD, reported that the Active Membership category had increased by 74 members since last April. The Board adopted a special Resolution to commend Fay Miles for her nearly thirty years of service to KEMPAC and KMA, to be presented at a staff retirement luncheon on June 8.

Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, reported in detail on the recently completed Kentucky General Assembly. Doctor Montgomery presented a slide presentation which highlighted 229 bills, of 1,800 introduced, that KMA had monitored throughout the Session. Recent developments regarding attempts by nurse practitioners to prescribe were also discussed.

Russell L. Travis, MD, Chairman of the KPC Operating Committee, reported that negotiations are underway with a major drug company to obtain 100% of its product line for the KPC program. The Board directed the Committee on Constitution and Bylaws to present proposed changes in the Bylaws pertaining to Life Members to the House of Delegates; and approved payment of expenses for directors of impaired physicians programs in other states to meet with the KMA Committee on Impaired Physicians.

The Board members adopted a budget for the 1990-91 Associational year; approved a slate of directors to be elected to the KMIC Board, and changes to the KMIC Articles of Incorporation. Legal Counsel presented an update on two lawsuits of interest to KMA, including one in which an amicus curiae brief had been filed on behalf of the Association.

Above, **Secretary-Treasurer S. Randolph Scheen, MD, gave his annual report.** ***Right,*** **Auxilian Gloria Griffin presented AMA-ERF checks to Dean Donald R. Kmetz, MD, University of Louisville School of Medicine (center), and Dean Emery A. Wilson, MD, University of Kentucky College of Medicine. U of L received $27,378.73 and UK $18,514.23.**

The application of the Kentucky Geriatric Society for specialty group recognition was approved; and it was voted to submit the name of Ardis D. Hoven, MD, Lexington, to the AMA for consideration of appointment to its Women in Medicine Advisory Panel. The Board then selected names for submission to the Governor for the Kentucky Board of Medical Licensure and the Nurse Practice Council.

The Committee on Medical Insurance and Prepayment Plans asked the Board to consider submitting a Resolution to the AMA House of Delegates resolving that AMA introduce amendments to PL 93-406 requiring self-insurance health care plans to be subject to the authority of state insurance regulations. The Board approved submission of the Resolution to the AMA, and also asked staff to investigate the complaint of a member regarding Worker's Compensation reimbursement.

The Chairman announced that the Board would hold its next meeting in August. *kma*

The Board received a membership update from Chairman Harold D. Haller, MD.

PEOPLE

Eugene H. Kremer, III, MD

Eugene H. Kremer, III, MD, was recently installed as President of the American College of Occupational Medicine (ACOM), an international organization of more than 5,200 physicians who provide health care to the world's work force.

Dr Kremer, in private practice at the Occupational Physician Services of Louisville, took office at the College's 75th annual business session held in Houston.

Also an Assistant Clinical Professor of Occupational Medicine at the University of Kentucky, Dr Kremer is a diplomate of the American Board of Preventive Medicine, certified in occupational medicine. He earned his MD from the University of Louisville in 1963.

A member of ACOM since 1965, Dr Kremer attained the designation of Fellow in 1974. He has served on the ACOM Board of Directors, and as Treasurer, Second Vice President, First Vice President, and as President-Elect. He is a Past President of the Kentucky Occupational Medical Association, one of 29 ACOM component societies.

Russell L. Travis, MD, Chairman of the Kentucky Physicians Care Program, was invited to speak at the New Hampshire Medical Society's Annual Meeting on June 9, 1990. Dudley J. Weider, MD, president of the Society, had heard Dr Travis speak on the KPC Program last year at the AMA Leadership Conference and was so impressed with his message that he wanted the New Hampshire membership to hear it. The innovative KPC Program continues to receive positive publicity throughout the US.

Salvatore J. Bertolone, MD, a Louisville oncologist, is among the winners of the JCPenney Golden Rule Awards for Outstanding Volunteer Service. Dr Bertolone is president of Hospice of Louisville, a dedicated group that for the last 11 years has offered support to patients and families coping with a terminal illness. The volunteers provide respite care and contribute their hours to clerical and office functions.

Seven KMA members recently received 3 year appointments as Cancer Liaison Physicians for the Cancer Program in a hospital in their area. Included were **Wally O. Montgomery, MD,** Lourdes Hospital, Paducah; **J. Wesley Johnson, MD,** King's Daughters Medical Center, Ashland; **Robert E. Robbins, MD,** Hardin Memorial Hospital, Elizabethtown; **Aubrey L. Armstrong, MD,** Muhlenberg Community Hospital, Greenville; **John Rawlings, MD,** Kings Daughters Memorial Hospital, Frankfort; **Fazal H. Ahmad, MD,** Harlan ARH Regional Hospital, Harlan; and **Horacio E. Reinoso, MD,** Pineville Community Hospital, Pineville. The Cancer Liaison Program is an integral part of the Commission on Cancer of the American College of Surgeons.

These physicians are among a national network of 2,300 volunteer Cancer Liaison Physicians who provide leadership and support to the Hospital Cancer Program, and other Commission on Cancer activities.

They have a significant interest in the diagnosis and treatment of patients with malignant disease, and also provide local leadership for the annual national clinical goal of the Cancer Liaison Program; the 1990 goal is the promotion and utilization of tumor nodes metastases staging.

Established in 1956, the Commission on Cancer, which is composed of Fellows of the College and liaison members representing 23 other cancer-related organizations, has approved more than 1,200 cancer programs in hospitals across the country. The Commission reviews each hospital's cancer program for conformity to high standards set by the Commission, and encourages participating hospitals to equip and staff themselves so that they are able to provide the best in the diagnosis and treatment of cancer.

Recognizing that cancer is a complex group of diseases, the Cancer Liaison Physician promotes extensive communications and consultation among family physicians, surgeons, medical oncologists, diagnostic and therapeutic radiologists, pathologists, and other cancer specialists as a means of providing better patient care.

An integral part of a hospital's cancer program is its tumor registry. The Cancer Liaison Physician provides support and technical expertise to the hospital's tumor registrar and encourages medical staff at his or her institution to use data generated by the registry. All patients who are diagnosed as having cancer or are being treated for the disease are listed in the registry so that the hospital can maintain contact with them and make sure that they receive continuing care and assistance with rehabilitation.

Information collected through the registry allows these physicians' institutions to participate in national studies that are designed to improve patient care. Each year since 1976, more than 500 hospital cancer programs have collaborated with the Commis-

sion on these studies. Some of the most extensive incidence and survival statistics in the world have been amassed through this nationwide effort, resulting in the publication of 54 manuscripts in professional journals.

The American Cancer Society estimates that 1,040,000 cases of cancer (exclusive of carcinoma in situ — or noninvasive cancer — and nonmelanoma skin cancers) will be diagnosed during 1990. Although only one-sixth of the hospitals in the United States have cancer programs approved by the Commission on Cancer, 68% of new cancer patients are treated in these hospitals.

For more information on the Cancer Liaison Physicians Program, the Hospital Cancer Program, or the Commission on Cancer, please contact the Cancer Department at the American College of Surgeons, 55 East Erie Street, Chicago, IL 60611, (312) 664-4050.

UPDATES

Regional Hansen's Disease Program

The Department of Health and Human Services reports that the Regional Hansen's Disease Program provides medical services to Hansen's disease patients throughout the US, and that in order to achieve the program's goal of providing care in each patient's community, a nationwide network of over 900 physicians has been developed. Network physicians represent numerous medical specialties, have varied backgrounds, but share a common interest in managing Hansen's disease patients.

According to the Department of Health and Human Services, there are approximately 6,000 patients with Hansen's disease living in the US today. The Regional Hansen's Disease Program has identified 3,700 of these patients as currently being under treatment. In an effort to identify additional cases, the Department is requesting physicians following Hansen's disease patients to contact the program.

Physicians who choose to utilize the program's resources can obtain medications, patient education materials, insensitive limb screening materials and clinical literature at no charge. Any physician with an interest in managing Hansen's disease patients can be placed on the program's referral list. Interested physicians should contact Mr Larry Pfeifer, Clinical Coordinator, at 1-800-642-2477.

Adolescent Health

America's Adolescents: How Healthy Are They? is the first volume of the "AMA Profiles of Adolescent Health," a series of new books from the AMA. Written in a simple question and answer format, the publication can be used for advocacy, research, proposals, reports, presentations, and program planning.

Now available for purchase, the book (Order #NL012690) can be ordered by calling toll free 1/800/621-8335. Price: $10, AMA and AMA Auxiliary members; $12, non-members.

Light-activated Drug Fights Some Incurable Cancers

A light-activated drug is offering new hope for patients with incurable lung, esophagus, and breast cancers, according to the University of Louisville.

U of L cancer researcher **Jeffrey Wieman, MD,** is using an experimental treatment called photodynamic therapy. He injects a drug that collects in tumors. Initially inert, the drug becomes active when exposed to certain wavelengths of light and destroys the tumor in which it is concentrated.

The University reports that many of the 15-20 patients who have undergone the therapy have responded to the treatment.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Fayette

Jacqueline R. Matar, MD — R
130 Million Ln, Versailles 40383
1985, U of Kentucky

David R. Stigers, MD — AN
1007 Chinoe Rd, Lexington 40502
1985, U of Kentucky

Hardin

Sidney M. Verble, Jr, MD — PATH
Hardin Mem Hosp, Elizabethtown 42301
1984, U of Tennessee

Nestor Gutierrez, MD — R
175 Ridge Pole Rd, Brandenburg 40108
1959, National U, Columbia

Jefferson

Steven M. Bloom, MD — OPH
224 E Broadway #410, Louisville 40202
1984, Medical Coll of Pennsylvania

Ann E. Roberts, MD —FP
4003 Kresge Way #332
Louisville 40207
1986, U of Louisville

Leslie

Ira J. Azizpour, MD — OBG
PO Box 1684, Hayden 41749
1968, Tabriz U, Iran

Logan

Patrick K. Hayden, MD — FP
1621 S Nashville #106, Russellville 42276
1986, U of Kentucky

Madison

Richard A. Stone, MD — S
789 Eastern Bypass #23, Richmond 40475
1978, U of Louisville

Mason

Allen L. Tinsley, MD — IM
1340 Medical Park Dr, Maysville 41056
1986, U of Louisville

McCracken

Mark Daniel Lineberry, MD — C
672 Whitney Dr, Paducah 42001
1982, U of Louisville

Northern Kentucky

Robert L. Corgan, MD — FP
741 Central Ave, Newport 41071
1983, U of Kentucky

James P. Farrell, MD — N
3054 Balsam Ct, Edgewood 41017
1983, U of Kentucky

Patricia R. Miles, MD — IM
520 Oak Ridge, Edgewood 41017
1984, U of Louisville

Russell

John D. Kilgallin, MD — FP
Lake Cumberland Med Arts, Russell Springs 42642
1986, U of Kentucky

Warren

John W. Culclasure, MD — AN
712 Hard Scuffle Ct, Bowling Green 42103
1983, Medical U of South Carolina

Kenneth B. McCollum, MD — AN
271 Mooreborough Dr, Bowling Green 42103
1955, U of Texas

New In-Training

UK —
John R. Meek, MD — **ID**
George M. Werdick, MD — **S**

UL —
Donald R. Atkinson, MD — **P**
Eddy H. Carrillo, MD — **S**
Madeleine C. Heck, MD — **ID**
Evelyn M. Jones, MD — **IM**
Holmes B. Marchman, MD — **PM**
Sheila A. O'Grady, MD — **IM**
Edward D. Sledge, Jr, MD — **IM**

DEATHS

Roy Mason Kash, MD
Winchester
1918-1990

Roy Mason Kash, MD, an ENT physician, died March 19, 1990. Dr Kash was a 1943 graduate of Duke University School of Medicine and was a life member of KMA.

Millard C. Loy, MD
Columbia
1918-1990

Millard C. Loy, MD, a family practitioner, died April 7, 1990. Dr Loy was a 1946 graduate of the University of Louisville School of Medicine and had been a member of KMA since 1947.

Charles B. Daniels, MD
1904-1990
Ashland

Charles B. Daniels, MD, died April 7, 1990. A 1930 graduate of the University of Louisville School of Medicine, Dr Daniels had been a member of KMA since 1932.

John J. Wolfe, MD
Naples, Florida
1903-1990

John J. Wolfe, MD, a former Louisville plastic surgeon who developed a bath treatment for third-degree burn victims, died April 21, 1990. He was former head of the plastic surgery department at U of L School of Medicine. Dr Wolfe graduated from Yale Medical School in 1933 and was a life member of KMA.

Leslie W. Blakey, MD
Lexington
1917-1990

Leslie W. Blakey, MD, a neurologist, died May 5, 1990. A 1947 graduate of the University of Louisville School of Medicine, Dr Blakey served as President of the Fayette County Medical Society in 1971 and was a life member of KMA.

Eugene H. Kremer, Jr, MD
Louisville
1905-1990

Eugene H. Kremer, Jr, MD, a general practitioner, died May 9, 1990. Dr Kremer graduated from the University of Louisville School of Medicine in 1930. He was past president of the Kentucky Occupational Medical Association and was a life member of KMA.

William C. Young, MD
Hopkinsville
1932-1990

William C. Young, MD, a pediatrician, died May 24, 1990. A 1960 graduate of Vanderbilt University, Dr Young had been a member of KMA since 1964.

Reporting on Risk: Getting It Right In An Age Of Risk

Victor Cohn

Published by The Media Institute
Publicatians Department
3017 M Street, NW
Woshington, DC 20007

$8.95 + postoge.

Mr Cohn, a well-known and accomplished science reporter, explores with the reader the current methods of evaluating scientific material. Really addressed to the new reporter, this book reads well for those interested in editorial work. It also distills in layman terms such statistical verbiage as real and perceived risk, probability, morbidity, etc.

Initially we are introduced to the scientific world, from the columnist perspective. Political pressure, actual or just palpable, is accepted as part of the atmosphere. Economic factors, entrepreneurs, and big business want control of the information and may manipulate the news for their benefit. Neonatal writers are vulnerable to forces abutting on their bias. Next, what can go wrong, what errors have befallen predecessors, are discussed with all the caveats of a caring teacher to his students. Beware of the "Trojan Horse" covering potentially malignant information.

Then a nice, more relaxed pedantic chapter on the rules of science and statistics gives the reader a cozy, if still amateurish, relationship with this material. Nevertheless, the basic working tools are all there, and the reader who does his homework here will pass the tests of his acumen to come.

Specifics of environmental reporting — certainly the current genre — are addressed clearly, though already somewhat dated in their relevance. Issues of daily life (driving, construction work, etc) are then dealt with by example and by pronouncement.

To make his fellow reporters look good, Mr Cohn even supplies questions, or at least the format for an interview, in a fatherly manner. He is not much of a gunslinger, shooting queries from the hip. With scientific material, too much can be documented and mistakes are easily visible.

Easy to read, informative and intriguing, this book is a nice primer for the news writer and for those of us who sometimes make the news.

Stephen Z. Smith, MD

Make Your Reservations Now

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 24-27. The Hyatt Regency Louisville will be the Headquarters Hotel (Phone (502) 587-3434). In making your reservations, remember the first House of Delegates meeting will be Monday, September 24. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

WESTERN KENTUCKY — Seeking physicians for evening and weekend coverage in a low volume emergency department. Attractive schedule and compensation. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc, 2240 South Airport Road, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

KENTUCKY — EM staff physician needed for rural community hospital in southeastern KY. Annual volume 11,000. Compensation $80,000-$120,000, plus malpractice procured for you. Independent contractor status. Send CV to Liz Shannon, Coastal Emergency Services of Kentucky, Dept SJE, PO Box 639, Whitley City, KY 42653. (606) 376-5083.

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References
1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

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2. Dosage should be reduced in patients with moderate to severe renal insufficiency.

3. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Additional information available to the profession on request.

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1990 KMA LEGISLATIVE REPORT

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FOREWORD

The 1990 Kentucky General Assembly is history, and its impact upon the Commonwealth's future will be evident for years to come. The enactment of HB 940 in response to the Supreme Court's decision ruling Kentucky's education system unconstitutional and the subsequent $1.2 billion tax increase to fund the reform package, dominated the Session. There were other far-reaching proposals enacted which will improve our highway system and bring Kentucky's prison system into compliance with court orders.

The health agenda was dominated by the Certificate of Need (CON) controversy granting Jefferson County hospitals exemption from CON. On a more positive note, important health legislation relating to indigent care, AIDS, Living Will, and protection of retirement plans from judgment was approved by the 1990 Kentucky General Assembly.

During the Session, KMA closely monitored over 225 bills which directly or indirectly affected the practice of medicine. We had a very successful Session which had as its roots strong cooperation among members, Board of Trustees, and staff.

Special recognition goes to the 138 men and women of the Kentucky General Assembly for their leadership and support on issues of concern to our patients and the profession. I would be remiss for not calling to your attention Wally O. Montgomery, M.D., Chairman of KMA's state legislative activities. His tireless efforts and dedication were an inspiration to us all.

Nelson B. Rue, Jr., M.D.
President

COMMITTEE ON STATE LEGISLATIVE ACTIVITIES

KENTUCKY MEDICAL ASSOCIATION

REPORT OF THE 1990 KENTUCKY GENERAL ASSEMBLY

WALLY O. MONTGOMERY, M.D., CHAIRMAN

MESSAGE FROM THE CHAIRMAN

We are pleased to present the final report of legislation relating to health/medical issues considered by the 1990 Kentucky General Assembly (KGA). The 1990 Session was extremely difficult, operating at full throttle from opening bell to adjournment. This report summarizes approximately 200 bills which KMA followed.

KMA's legislative position is dictated by House of Delegates reports and resolutions; Board of Trustees policy and directives; Committee on State Legislative Activities recommendations; and specialty group consultations when bills directly affect a particular group. The KMA Quick Action Committee (QAC) and the Chairman of the State Legislative Committee are charged with the responsibility of implementing the legislative agenda and directing the lobbying effort.

In 1980 the KGA made a dramatic and historical departure from previous Sessions in which the Governor traditionally exercised tight-fisted control over the legislative process. Succeeding Sessions of the KGA have been marked by a sharp division between the Governor and legislative leadership over separation of powers and equal branches of government. The 1990 Session represented the high-water mark in the KGA's quest for total independence.

The power struggle between executive and legislative branches has had an enormous impact upon KMA's strategy. Rather than negotiating with the Governor, we now find ourselves working with 22 of the 36 standing committees and lobbying 138 members of the KGA on a weekly basis. Secondly, physician participation has been altered substantially from an "arm's length" role to a "hands on" and active involvement in the process. The QAC meets weekly with staff to review legislation, establish positions, and coordinate legislative strategy. KMA leadership is called upon frequently to testify and meet with legislators and staff on technical matters that require physician input and decision. Finally, legislative independence has had a direct effect upon constituents of legislators. A critical element in KMA's strategy is the physician residing in the legislator's district which consequently requires members to be involved year around with their Senator and Representative.

Significant legislation was adopted or considered during the 1990 Session directly affecting medical practice. Eight issues were extremely time consuming and stand out as highlights of the 1990 Session.

(1) Protection of retirement plans from judgment - HB 553. This legislation will provide for a full statutory protection of "qualified retirement plans" from judgment and, also, exclude "qualified retirement plans" from the estate in the event of bankruptcy. The

highly technical nature of HB 553 precludes detailed explanation here. However, there is little doubt that passage of this bill was a highlight of KMA's legislative session and should be viewed in a very positive manner by physicians and others.

(2) AIDS. HB 425 includes the entire package of AIDS provisions adopted by the 1989 KMA House of Delegates. HB 425 permits physicians to use the general consent to treatment form signed by all patients as informed consent for testing patients for HIV; exempts physicians from obtaining informed consent in emergency situations; allows physicians to disclose HIV infections to spouses; makes all protection rights of handicapped available to HIV patients; and prohibits discrimination.

(3) Certificate of Need - SB 68. While the Jefferson County hospital exemption drew most of the media's attention, it is important that you be aware that on three separate occasions KMA defeated amendments that would have brought physicians' offices under the CON provisions.

(4) Confidentiality of Peer Review - HB 657. Reenacts COPR which was ruled unconstitutional by the Kentucky Supreme Court in June 1989.

(5) Omnibus Health Care Act of 1990 - SB 239. While KMA opposed provisions relating to the mid-level practitioner, SB 239 represents landmark legislation by attempting to address problems relating to rural and indigent patients access to care; hospital and physician reimbursement; physician and nursing education; etc.

(6) Utilization Review - HB 781 and SB 236 address abuses to the UR concept and provide protection to patients and providers from overzealous claims review agents representing peer review organizations and insurance companies.

(7) Inroads to medical practice by nonphysician practitioners. Unsuccessful attempts by nonphysician practitioners included nurse practitioners (HB 86 and SB 100); optometrists (HBs 188 and 189 and SB 100); chiropractors (HB 856); paramedics (HB 880); psychologists and clinical social workers (HB 450 and SB 221).

(8) HB 799 - The 1990-92 budget updates physician reimbursement under Medicaid by $18 million. It also increases funding for vaccine programs, prenatal, and pediatric care.

We hope you find this report educational and helpful as you work with your elected representatives during the Interim. We would appreciate any comments you might have on the Session. Your kind words, notes of encouragement, and assistance during the Session are deeply appreciated. On behalf of leadership and staff, we thank you for your involvement in the 1990 Session.

Wally O. Montgomery, M.D., Chairman
Committee on State Legislative Activities

This handbook contains brief summaries of legislation relating to health care and medical practice. If the reader has interest in a particular bill, a full copy may be obtained by contacting the Legislative Research Commission at 502-564-8100.

The 1990 Kentucky General Assembly adjourned on April 13, 1990. During the Session 1,825 bills and resolutions were introduced. The breakdown of adopted bills is as follows:

Senate Bills (SB)	**140**
Senate Concurrent Resolutions (SCR)	**17**
Senate Joint Resolutions (SJR)	**6**
Senate Simple Resolutions (SR)	**158**
TOTAL	**321**
House Bills (HB)	**308**
House Concurrent Resolutions (HCR)	**14**
House Joint Resolutions (HJR)	**11**
House Simple Resolutions (HR)	**222**
TOTAL	**555**
TOTAL BILLS BOTH CHAMBERS	**876**

Two bills, HB 929 and HJR 185, became law without the Governor's signature. The Governor vetoed 22 bills and the General Assembly subsequently overrode 14 of the vetoes, thus sustaining vetoes on 8 bills.

Of the 876 proposals enacted, 380 were simple resolutions which are adopted only in the originating chamber by voice vote. In terms of regular Senate and House bills, 1,350 were introduced with only 448 enacted.

The following Legend will assist you as you study this book:

LEGEND

Bold Type	Legislation adopted by the General Assembly.
*Asterisk	Refers to KMA House of Delegates report and Resolutions
COSLA	Committee on State Legislative Activities
SB Senate Bill	HB House Bill
SCR Senate Concurrent Resolution	HCR House Concurrent Resolution
SJR Senate Joint Resolution	HJR House Joint Resolution
SR Senate Simple Resolution	HR House Simple Resolution

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AIDS/COMMUNICABLE DISEASES

HB 139 Defined HIV infected persons as physically handicapped; prohibited discrimination for employment and housing. Required specific, written informed consent before testing for HIV. Required pre- and post-test face-to-face counseling. ***Opposed per COSLA Report-1989 House of Delegates***

HB 165 Required CHR to develop a state plan to prevent the spread of HIV. Required physician treating HIV positive patient to either provide information, counsel, or refer to an appropriate professional or agency for counseling. ***Opposed per COSLA Report-1989 House of Delegates***

HB 324 Required emergency personnel be notified by health facilities if they transport persons with a communicable disease for which blood and body fluid precautions are required. ***Opposed***

HB 343 Required health facilities to notify embalmers or funeral directors receiving diseased bodies of the presence of specified communicable diseases. ***Opposed***

HB 425 **Allows health care providers to use the general consent to treatment form signed by all patients as informed consent for testing those patients for the Human Immunodeficiency Virus (HIV); limits use of test results performed under a general consent form to diagnostic or other purposes related to medical treatment; exempts health care providers from obtaining informed consent in an emergency situation; requires the physician ordering the HIV test to be responsible for informing the patient of any positive test results and for providing or referring the patient for information and counseling; prohibits testing for the HIV virus without obtaining informed consent except in emergency situations or when the patient has signed a general consent to treatment form; and prohibits persons obtaining or having knowledge of an HIV test result from disclosing or being compelled to disclose the identify of the person tested except for specified parties under conditions as set forth. Requires CHR to educate the public about AIDS, including courses for law enforcement officers, health workers, correctional employees, college freshmen and transfers. Establishes education and testing programs for inmates of correctional institutions; prohibits sale of HIV self-testing kits; includes HIV as a sexually transmitted disease;**

allows physicians to disclose HIV infection to spouse; makes all protection rights of handicapped available to HIV patients. Requires organ donations to be tested by receiving facility. ***Supported per Resolutions L, Y and Z - 1989 House of Delegates.*** **ADOPTED**

SB 207 **Changes existing law which allows exclusion from school of the entire family of a person with a communicable disease. The new law authorizes school superintendents to exclude from school any student infected with a communicable disease or condition for which reasonable probability for transmission exists in a school setting; provides for superintendent to consult with student's physician or health officer in determining time period student is excluded.** ***Supported.*** **ADOPTED**

SB 233 The amended version of this bill required that EMS personnel sustaining blood or body fluid exposure notify the medical facility to which the offending patient is admitted of such exposure; the facility must then inform EMS personnel if that patient is diagnosed with HIV or Hepatitis B infection; testing in such situation was to be conducted at the discretion of the attending physician. ***Opposed***

ABORTION

HB 357 Provided income tax refund check-off to fund alternatives to abortion programs; required physicians to make a determination of viability prior to performing an abortion. ***Monitored***

HB 710 Prohibited abortions for reasons of convenience. ***Monitored***

HB 899 Required viability testing by physician prior to performance of abortion; prohibited aborting a viable fetus unless life of mother was in jeopardy. ***Monitored***

SB 357 Companion to HB 710. ***Monitored***

SB 358 Companion to HB 357. ***Monitored***

ALCOHOL/DRUGS

HB 105 Included deaths resulting from provision of Schedule I, II, or III controlled substances as murder, making defendant eligible for death penalty. ***Monitored***

HB 122 Alcohol and drug prevention, intervention and treatment; allowed any intoxicated person admitted to alcohol/drug abuse center to receive treatment; prohibited hospitals from refusing to admit alcohol/drug abusers for treatment. ***Monitored***

HB 510 **Requires alcohol/drug treatment centers to submit annual reports to CHR to receive funds; requires follow-up studies and evaluates centers annually.** ***Monitored.*** **ADOPTED**

HB 762 Prohibited use, sale, distribution, manufacture, dispensation or possession of drugs and alcohol by state employees. ***Monitored***

HB 763 Implemented the requirements of the Federal Drug-Free Work Place Act of 1988 in Kentucky State Government. ***Monitored***

HB 766 Required courts convicting persons between ages 13 and 18 of offenses relating to controlled substances, alcohol intoxication, or drinking in public to notify Transportation Department and revoke drivers' license. ***Monitored***

HB 876 Permitted discharge of state employees who use illegal drugs while conducting state business or operating state vehicle; permitted random testing and discharge of those in "safety-sensitive" positions. ***Monitored***

SB 160 Prescribed felony penalties for selling drugs near (1500 yards) specified public facilities; required juveniles to be tried as adults; imposed fines and punishment and required serving 50% of term before eligible for parole. ***Monitored***

BLOOD DONATIONS

HB 482 Allowed 17 year olds or under to donate blood without parental consent. ***Opposed***

HB 757 Specified that autologous blood donation programs are not considered blood establishments subject to licensure. ***Supported***

BOARDS OF HEALTH

HB 188 Required publishing annual summary of Board of Health revenues and expenditures. Required itemized listings, salaries, etc.; added optometrist and engineer to all county boards of health. ***Opposed.*** **ADOPTED BUT VETOED BY GOVERNOR**

HB 189 Altered the physician compliment on County and District Health Boards. Eliminated registered nurses, veterinarians and dentists as mandatory members of the district board. In the case of both the county and district boards, a member's absence from three consecutive board meetings would constitute grounds for removal. An amendment required an optometrist and engineer be added to each Board. ***Opposed***

HB 380 Companion to SB 166 below.

SB 166 **Permits creation of independent district health departments by county fiscal courts where district health departments exist and where counties are part of an interstate MSA (Northern Kentucky).** ***Supported.*** **ADOPTED**

BOARD OF MEDICAL LICENSURE

HB 254 **The Medical Licensure Board's (BML) ability to promulgate regulations dealing with licensee conduct is made clear; the BML's ability to create advisory committees made up of physicians other than board members and which committees may make recommendations concerning issues of public or medical interest, is established; the entry of a guilty or nolo contendere plea is established as grounds for denial, revocation, suspension, restriction or probation of a license; authority, at the Board's discretion, to provide advisory opinions concerning issues of appropriate public or medical interest is granted; and, the proposal establishes that there will be no monetary liability and no cause of action for damages against members or others involved in the regulatory process as a result of their activities unless actual malice is shown or willful misconduct is involved.** ****Supported per COSLA Report-1989 House of Delegates.*** **ADOPTED AS AN AMENDMENT TO SB 246.**

HB 550 Established venue for agency regulatory actions in the Circuit Court of the County in which the cause arose, or in the Circuit Court in the County where the defendant resides. ***Opposed***

CHILD ABUSE

HB 298 Prohibited possession of material depicting a child engaging in a sexual performance. ***Monitored***

HB 663 **Requires assessment of children abused or neglected to determine educational needs.** ***Monitored.*** **ADOPTED**

HB 843 Related to record checks for individuals dealing with children. ***Monitored***

HEALTH

HB 115 **Relates to alcoholic beverage control investigators. An amendment requires establishments that sell alcoholic beverages to post warnings that drinking alcoholic beverages during pregnancy can cause birth defects.** ***Supported per Resolution N-1988 House of Delegates.*** **ADOPTED BUT VETOED BY GOVERNOR.**

HB 443 **Prohibits promulgation of rules, bylaws, or regulations which prohibit pupils in grades 5-8 from participating in high school sports or from participating on more than one school-sponsored team at the same time. The bill was amended to provide that pupils in grades 7-8 are exempt from regulations rather than grades 5-8.** ***Opposed.*** **ADOPTED**

HB 790 Developed training and pilot programs in respite care for Alzheimers patients; awarded grants to medical schools or hospitals to assist institutions in their diagnostic and research efforts; appointed a task force to study Alzheimers. ***Monitored***

HB 862 Established a medical and clinical service program for individuals over 21 who suffer from cystic fibrosis. ***Monitored***

HCR 159 **Directs the formation of a task force to conduct a study of alcohol and drug use during pregnancy.** ***Supported.*** **ADOPTED**

SB 41 Breast Cancer Screening - See under Indigent Care.

SB 159 Exempted tanning equipment and tanning facilities from any type of registration, licensing or regulations. ***Opposed***

HOSPITALS

HB 931 Exempted specified hospital services with capital expenditures less than $1 million from CON but not from licensure requirements.***Opposed per COSLA Report-1989 House of Delegates***

SB 68 **Certificate of Need. Increases thresholds to $1.5 million for capital expenditures and major medical equipment before CON is required. Operating cost threshold is eliminated, and the HMO exemption is deleted.**
The following services, provided on-site by any health facility, are

permitted if the cost is less than $600,000 and they are established prior to December 30, 1991:

- **Psychiatric care where chemical dependency services are provided.**
- **Levels I and II neonatal care.**
- **Cardiac catheterization and open heart surgery where cardiac catheterization services are in place as of July 15, 1990.**

Exempts acute care hospitals located in counties with 3,000 acute care beds (except for rehabilitation or long term care beds) beginning September 15, 1991. There is no allowance for these hospitals to begin construction, to establish services, or acquire equipment prior to the September 15 date. The legislation also creates a Jefferson County Task Force to study and report on the implementation of the Act.

On appeal of a determination made by the Commission, the Circuit Court's decision is final and non-appealable; challengers are required to post a bond if they initiate an appeal of an approved CON. Applicants can make a motion for a reconsideration hearing if application is denied and there was no public hearing conducted.

Exempts from CON the construction of Alzheimers facilities if they are completed by July 15, 1991, and do not receive governmental funds for five years; boarding homes that do not receive Medicare or Medicaid payment and are operating prior to July 15, 1990, are also exempt. **Opposed per COSLA Report-1989 House of Delegates.* ADOPTED

SB 80 Exempted acute care hospitals from CON. ****Opposed per COSLA Report-1989 House of Delegates***

SB 265 **Prohibits hospital-based long-term care (LTC) facilities from being considered in determining the need for free-standing LTC facilities. Amends KRS 216B.040(2) re: State Health Plan assessment for LTC beds. *Monitored.* ADOPTED**

EXAMINATIONS

HB 633 **Adds incest to the list of offenses for which hospital-based examinations are to be made available. *Supported.* ADOPTED**

COSTS

HB 492 Created a Department of Health Care Consumer Information and required hospitals and ambulatory facilities to report price and quality information regarding medical conditions and health care services. ***Monitored***

RATE REVIEW

HB 649 Established a seven-member commission, analogous to Kentucky's PSC, to regulate rates and budgets of all Kentucky hospitals. ***Opposed***

CANCER REGISTRY

SB 41 **An amendment to SB 41 establishes the Kentucky Cancer Registry and cancer patient data management system administered by UK Markey Cancer Center; requires acute hospitals to report cancer cases to the registry; requires Markey Center to provide staff assistance in compiling and reporting required information to hospitals treating a low volume of patients.** ***Supported Amendment - Opposed portion of bill relating to screening program.*** **ADOPTED**

UTILIZATION REVIEW

HB 781 **Requires registration of utilization review agents under CHR; sets forth requirements for private review agents; specifies that licensed physicians supervise UR activities in consultation with other physicians; requires private review agents be accessible 40 hours/week instead of 5 working days; requires hearing officers to have health insurance hearing experience; $1,000 penalty for failure to register.** ****Supported per Resolution W-1986 House of Delegates.*** **ADOPTED**

SB 246 **Requires agencies which conduct UR of hospital or medical services to obtain a certificate from CHR; mandates every health insurance plan which performs UR to have a certificate or contract with a certified agent to conduct UR.** ****Supported per Resolution W-1986 House of Delegates.*** **ADOPTED**

INDIGENT CARE

HB 141 Appropriated $6.5 million for each year of the upcoming biennium to establish a Kentucky Quality and Charity Trust Fund to pay for hospital care of the medically indigent in Northern Kentucky. The $6.5 million appropriation was based on a $24.96 per capita assessment using Northern Kentucky population figures. The bill also appropriated $1.5 million to be used to finance four demonstration projects that would ". . . test alternatives for providing affordable sickness and accident health insurance benefits." ***Monitored***

HB 233 Established a trust fund to receive 50% of net proceeds of lottery of which 45% was to be used with matching Federal funds to increase income eligibility in the Medicaid and AFDC programs. ***Opposed***

HB 774 Enabled area development districts to create health insurance trusts for small employers with minimun benefit requirements; provided decreasing tax credits to small employers paying half the cost of employees for the first time. ***Monitored***

HR 157 **Recognizes, appreciates, and thanks physicians of Kentucky and the KMA for providing medical care for the uninsured through the Kentucky Physicians Care program.** ***Supported.*** **ADOPTED**

HB 799 **The Governor's budget proposes an $18 million increase for physician reimbursement under KMAP. This increase will reimburse physicians participating in Medicaid at a rate of approximately 60% of 1980 profiles. In addition, 100,000 additional Kentuckians will become eligible for Medicaid benefits in fiscal year 1992. New funding is being provided for a major outreach and follow-up program for high risk pregnant women to reduce infant mortality and low birth weight babies. Prenatal benefits will be available to all low income women in need. Major efforts were proposed with lottery funds to extend Medicaid coverage to 185 percent of the Federal poverty level for pregnant women and their children up to age one. An expansion of well-child services and immunizations is also provided through local health departments. Also provided in the budget is:**
•$4.8 million in new funds over the biennium for well-child services resulting in two and a half times as many children receiving services.
•$2.2 million in new funds over the biennium for vaccine. ****Supported per COSLA Report-1989 House of Delegates and Ad Hoc Committee on Indigent Care-1987 House of Delegates.*** **ADOPTED**

SB 41 **Establishes a breast cancer screening program and fund; allows services to be undertaken by private contract or by CHR; allows programs to purchase, maintain and staff vehicle equipped to perform breast cancer screening; provides referral service for further examination or treatment; adopts fee schedule for screening and collecting insurance proceeds.** ***Opposed*** **ADOPTED**

SB 69 Required designated hospitals in cities of first class which receive funds for indigent care to reimburse other hospitals for the cost of providing care to indigent patients who could not be treated at the designated hospital because necessary services were not available. Also required the designated hospitals to accept transfers of indigent patients from other hospitals when services needed by those indigent patients are available. This legislation also limited these particular hospitals' payment for indigent care to the Medicaid reimbursement rate. ***Monitored***

SB 239 **The Omnibus Health Network establishes a new health care worker called the mid-level practitioner (MLP). The bill creates a Board of Family Health Care Practitioners to govern the health care delivery network system. This Board will be composed of 12 members, including six physicians, two nurses, one dentist, one pharmacist, a primary care association member, and a hospital association member. The MLP is prohibited from treating patients for initial consideration of medical problems and managing or treating acute conditions. Every encounter between the MLP and patient will be reviewed on the day of the encounter, and any deviation from the treatment plan or protocol must be immediately reported to the supervising physician. Maintenance medications used in treatment of chronic conditions must be dispensed to patients solely within the confines of the network, in accord with protocols and formulary approved by the Board and the treatment plan prescribed by a network physician; the charge is not to exceed the cost of the medication plus a one dollar ($1) dispensing fee. The bill also includes: Reimbursement for physicians providing services to Medicaid recipients shall be increased to reflect budgeted provider profiles beginning October 1, 1990, to 60% of 1980 profiles (physicians are presently reimbursed at 35% of their 1980 profiles). This would add approximately $18 million to the Medicaid reimbursement pool.**

Beginning October 1, 1992, Medicaid reimbursement to physicians shall be increased annually in increments which represent a minimum seventy-five percent (75%) of the most recently reported annual change in the consumer price index as computed by the U.S. Department of Labor. The bill creates a physician

recruitment and placement service at the colleges of medicine; requires colleges of medicine to design a streamlined course of study for family and general practitioners; redesigns nursing training programs; creates a multiple employer health insurance trust fund in 15 area development districts. Assesses each hospital .5% of the hospital's total revenue to be paid by hospitals on a quarterly basis (the money will be used to receive Federal funds on a 72-28 matching basis). The bill mandates health insurance for college students; penalizes health insurors for not using uniform claim forms; increases Medicaid payment to family practice physicians in certain underserved areas. ***Supported with Amendment.*** **ADOPTED.**

SB 324 — The KMA plan, entitled the Kentucky Medical Benefit Program (KMB), established a state-subsidized, limited health care plan designed to assist poor and low income working families who otherwise would not have access to medical care. The proposal called for five basic medical services, including physician services, inpatient and outpatient hospital care, laboratory and pharmacy services. Under the proposal, patients would be assigned a primary care physician who would act as patient care manager. ***Supported per Report of Ad Hoc Committee on Indigent Care-1987 House of Delegates***

SR 81 — **Urges the President and Congress to develop an adequate system of health care.** ***Supported*** **. ADOPTED**

INSURANCE

HB 52 — Established readability standards for health insurance policies. ***Supported per Resolution Y-1988 House of Delegates and Report of Ad Hoc Committee on Managed Care Systems-1989 House of Delegates.***

HB 53 — Required minimum standards for all health insurance contracts. ***Supported per Resolution Y-1988 House of Delegates and Report of Ad Hoc Committee on Managed Care Systems-1989 House of Delegates.***

HB 62 — **Mandates coverage for mammography under all health insurance policies; establishes a sliding scale for the number of mammography screenings available to various age groups and states that the insurance benefit may be limited to $50 per mammogram. Requires that the mammogram be performed by a state certified radiologic technologist and interpreted by a qualified radiologist; these services are to be provided and under the direction of a person licensed to practice medicine who is certified by the**

American Board of Radiology. Requires that two copies of the mammogram be sent to the physician ordering the test and one copy to the patient. *Opposed per House of Delegates long-standing position on mandated benefits.* ADOPTED

HB 207 Directs LRC to study the efficacy of HMOs and other managed care options as well as the cost savings to Kentuckians, if any, resulting from their use of HMOs and other managed care options as opposed to traditional health insurance. Report must be submitted by September 1, 1991. **Supported per Report of Ad Hoc Committee on Managed Care Systems-1989 House of Delegages.* ADOPTED

HB 267 Sets rules for extension of benefits when group health insurance policies are terminated or replaced; holds insurers liable for claims incurred during grace periods only if premium charges are paid to end of grace period; sets rules for the transfer of liability when one insurance group policy is replaced by another; provides reasonable extension of benefits during disability. **Supported per Report of Ad Hoc Committee on Managed Care Systems-1989 House of Delegates.* ADOPTED

HB 268 This bill establishes a number of items which must be considered by the Insurance Commissioner in determining whether or not premium increases for individual policyholders are appropriate. The bill also limits an insurer's ability to have successive rate increases, requiring that at least six (6) months must elapse following the effective date of the approved increase before another request may be filed. *Monitored.* ADOPTED

HB 450 Mandated mental health benefits and coverage for services provided by psychologists and clinical social workers. *Opposed per long-standing position of House of Delegates on mandated benefits.*

HB 586 Reinforces existing requirement concerning chiropractic treatment to indicate that HMOs may not unreasonably deny their enrollees coverage for such services. *Monitored.* ADOPTED

HB 626 Requires insurance that covers nonsurgical or surgical treatment of skeletal joint disorders to provide coverage for medically necessary procedures relating to temporomandibular joint disor-

der and craniomandibular jaw disorders. ***Opposed per long-standing position of House of Delegates on mandated benefits.*** **ADOPTED**

HB 631 See HB 626 above.

HB 641 Eliminated hospital and physician participating agreements with insurers; required health insurers to pay hospitals and providers directly and specified that the insured be notified when payment is made to the hospital or the physician. If the provider received payment in excess of charges, excess payment goes to the insured. ***Supported (House of Delegates long-standing position)***

HB 765 Exempted certain prepaid insurance plans from insurance code when provider and user are not in the business of insurance. ***Monitored***

HB 844 Permitted preferred provider options and contracts in the state employee health plans. ***Monitored***

HB 900 Allowed individual state government departments and district boards of education to form its employees into a group for health or life insurance, separate from the state master contract. ***Monitored***

SB 221 Required health insurance which covers services within the scope of a mental health professional to furnish reimbursement regardless of the profession of the provider. ***Opposed per House of Delegates long-standing position on mandated benefits.***

SB 278 See under Indigent Care.

SB 385 Required agents who sell life or health insurance to fully and reasonably explain coverage to applicants; set up a mechanism to determine if insurance complaints are valid; allowed insured or insurer to request a formal hearing after Commissioner's decision. ***Supported per Report of Ad Hoc Committee on Managed Care Systems-1989 House of Delegates.***

HB 491 Prohibited health care price discounting between non-governmental purchasers of health care in charges, price structures, discounts, rebates or other methods of preferential pricing. ***Monitored***

LIVING WILL, ETC.

HB 113 **Living Will. Deficiencies exist inasmuch as the bill specifically excludes the ability to withhold or withdraw nutrition and hydration. Concerns about this inadequancy were expressed but it was not politically feasible to address this issue. The proposal contains a definition of "terminal condition," modified to alleviate KMA concerns. The sponsor maintained a highly formalized process regarding creation of the living will, requiring an attestation process similar to that used for testamentary documents. There are limitations on those who may be subscribing witnesses. Because of this and other technical requirements, KMA expressed concern about a physician's duty to determine whether or not the will was executed in strict conformity with the statute. Attempts are made to alleviate that concern by establishing a presumption that the living will is validly executed unless the physician or health care facility has actual knowledge to the contrary. There are several affirmative duties placed on the physician: (1) to make the living will a part of the declarant's medical records once the physician has notice of the will's existence; (2) to proceed as medically indicated once notice of the living will's revocation has been received; and, (3) where there has been a refusal to comply with the directives of the living will, the physician may not impede the transfer of the declarant to another physician or health care facility willing to adhere to those directives. **Supported per COSLA Report -1989 House of Delegates.*** ADOPTED

SB 88 **This is the Health Care Surrogate Act, the Catholic Bishop Conference's alternative to the "Living Will." This proposal has the same practical effect as the living will, although it substitutes the decisions of the surrogate for the directive contained in the living will document. While the surrogate proposal does address nutrition and hydration, it does not do so in conformity with the AMA guidelines. The surrogate proposal has the disadvantage of requiring the availability and active participation of the named surrogate.**Supported per COSLA Report-1989 House of Delegates.*** ADOPTED

SB 250 Made assisting a suicide a Class D felony. This bill was intended to create a criminal offense that a prosecutor might rely on to reach a physician or surrogate who has been involved in a living will or health care surrogate situation. SB 250 would have made it a felony offense to aid, assist, or abet an individual in committing suicide. This was intended to have a chilling effect on those who would adhere to the directives of a surrogate or a living will document. ***Opposed***

SB 326 Allowed life-prolonging procedures to be withheld or withdrawn from a patient with a terminal condition who is incompetent and who has not made a living will declaration; required that there be consultation and a written agreement with next of kin or other specified parties who were listed in a required order of priority. ***Monitored***

MEDICAID

HB 355 Required life long-coverage for prescription drugs, hospital, laboratory and physician services related to an organ transplant if the patient was eligible for Medicaid when the transplant occurred. ***Monitored***

HB 448 Called for cost-based reimbursement predicated on customary and reasonable charges for long-term care facilities. ***Opposed***

HB 709 Established that a person may rely on the written advice of CHR agents or employees as a defense in a Medicaid fraud case. ***Monitored***

HB 859 Provided for chiropractic services under Medicaid; also called for including a representative of chiropractors on the Medicaid Advisory Council. ***Opposed***

SB 100 Mandated that all "certified" providers of services under Medicaid be allowed to bill Kentucky's Medical Assistance Program for the full allowable cost of medical services provided to those recipients. This bill also stated that the Medicaid Program would be responsible for recovering payment for those services ". . . which are the responsibility of third parties." The net effect of this legislation appeared to be to allow optometrists, CRNAs and other certified providers to bill Medicaid directly at the full physician rate. ***Opposed***

SB 101 Amended the Medicaid law to limit payments for health services provided in health departments to the amount paid to private physicians when they provided the same services. ***Supported***

SB 119 Required competitive bidding for all Medicaid and state employee insurance contracts, and non-emergency, inpatient hospital services. Any savings resulting from the competitive bidding process were to be used to reduce out-of-pocket expenditures for state employees or to augment the Kentucky Medical Assistance Program. There were also provisions relating to the rendition of such services in the Area Development Districts (ADD) where the Medicaid patient or state employee resided. ***Opposed***

SB 137 Created a new section of the Medicaid law to limit reimbursement for inpatient psychiatric treatment of patients under 21 years of age to 14 days per admission, or 28 days per calendar year. ***Opposed***

SR 114 **Urges Congress to prohibit HCFA from implementing a proposed rule which would disallow provider contributions as a basis for obtaining Federal Medicaid matching funds.** ***Supported.*** **ADOPTED**

MEDICAL EXAMINER

HB 418 Required state to pay for exhuming, transporting, or performing an autopsy on a body. ***Monitored***

HB 799 **Establishes funding for constructing a medical laboratory in Frankfort; includes funds for equipment and operating costs.** **** Supported per Resolution S-1989 House of Delegates.*** **ADOPTED**

MEDICAL PRACTICE

SB 40 Defined "health fairs" and exempted the laboratory testing performed at a health fair from the medical laboratory provisions act. In order for these procedures to be exempt, the health fair must have been under the supervision of a licensed physician. ***Opposed***

SB 49 Stated that medical records are the property of the patient and mandated a copy of records be made available to the patient upon request; allowed physicians to charge patients for cost of copying and mailing the medical record. ***Opposed***

SB 235 Created income tax credits for designated specialties who established practices in geographically underserved areas. ***Monitored***

MEDICAL SCHOOLS

SB 175 **Makes various acts of interference with the use of animals on farms and research facilities punishable under the penal code.** ****Supported per Resolution T-1989 House of Delegates.*** **ADOPTED**

SB 236 Required UK and UL medical schools to offer four-year programs on medical education; a four-year undergraduate degree would not be required prior to entry into this program. ***Opposed***

SB 239 See under Indigent Care.

SB 352 Exempted medical students from tuition if entering family practice, pediatrics, or OB/GYN if students agreed to practice in underserved areas. Double tuition would be repaid if practice moved from underserved area. ***Monitored***

MEDICAL WASTE

HB 31 Prohibited permits for incinerating solid waste until regulations to safeguard the environment were in effect. Required ash from the incinerators of solid waste, including medical waste, to be tested for hazardous materials. ***Monitored***

MENTAL HEALTH

HB 117 Related to admission and discharge of mentally retarded persons from a hospital or ICF. Established an interdisciplinary team to admit and discharge. ***Opposed***

HB 121 Related to hospitalization of mentally ill persons; allowed peace officers to take arrested and allegedly dangerous mentally ill persons to a hospital for evaluation; allowed change of venue, various appeals; prohibited privileged communication between mental health professionals and patients in certain legal proceedings. ***Monitored***

HB 337 Prohibited execution of mentally retarded. ***Monitored***

HB 511 **Proposes that admissions and discharges in mental institutions be made by an "interdisciplinary team," rather than a physician. KMA successfully amended bill to require physician to admit or discharge patient.** ***Monitored with amendment.*** **ADOPTED**

HB 838 **Defines "emotionally disturbed children and severely emotionally disturbed children"; requires state and regional contracts for coordinating services to emotionally disturbed children.** ***Monitored*** **. ADOPTED**

HB 888 Established examination and other criteria which must be applied in situations where children are committed to CHR for placement in an inpatient hospital for treatment of mental problems. ***Monitored***

HCR 110 Created a task force on involuntary hospitalization and treatment of the mentally ill and retarded. ***Monitored***

SB 85 Established a psychiatric security review board to supervise the treatment, rehabilitation and release of mentally ill persons who are convicted of crimes. ***Monitored***

SB 137 Prohibited Medicaid from reimbursing more than 14 days per admission or 28 days per calendar year for inpatient psychiatric treatment for any person 21 years of age of younger. ***Opposed***

SB 172 **Provides a procedure for court determination of retardation; sets IQ level for retardation purposes; requires defendant to produce evidence of retardation 30 days prior to trial; requires court to rule before trial begins.** ***Monitored.*** **ADOPTED**

SB 173 **Omnibus revision of guardianship laws; redefines interested person or entity.** ***Monitored.*** **ADOPTED**

SB 292 Community MH-MR services; omnibus proposal concerning mental health and mental retardation programs. ***Monitored***

MISCELLANEOUS

HB 16 **Calls for amending the Constitution to authorize the General Assembly to approve or reject administrative regulations during or between regular sessions of the General Assembly.** ***Supported.*** **ADOPTED**

HB 360 Related to open records, to add to the definition of "public agency" advisory committees and that portion of a corporation or other entity controlled by a public agency or which performs a public function. ***Opposed***

HB 361 Same provisions as HB 360. Restricted meeting size manipulation solely for the purpose of avoiding open meeting law requirements; opened all meetings of the parole board. ***Monitored***

HB 544 **Administrative Regulation review gives the Kentucky General Assembly complete veto power over regulations that have been found deficient by Standing or Interim committees.** ***Supported.*** **ADOPTED BUT VETOED.**

HJR 137 Created a task force to study the feasibility of a cabinet for environmental and health protection. ***Monitored***

NURSING

HB 86 Expanded Advanced Registered Nurse Practitioner practice to include the prescribing of medications, treatments and medical devices. An additional problem stemmed from the Nursing Board's attempt to arrogate power to itself. The person delegating authority in this instance would be the physician, over whom the Board of Medical Licensure (BML) has regulatory jurisdiction. If any delegation of the power to prescribe was to occur, it would have been pursuant to regulations promulgated by the BML rather than the Nursing Board. ***Opposed***

HB 107 **Establishes the Kentucky Nursing Incentive Scholarship fund; requires Nursing Board to make scholarship in two and four-year nursing degree programs available to low income, unemployed residents and LPNs.** ****Supported per Resolution W-1988 House of Delegates.*** **ADOPTED**

HB 341 **Allows hospice nurses to sign provisional reports of death and to make the actual determination and pronouncement of death where hospice patients are involved.** ***Supported*** **. ADOPTED**

HB 502 Defined the term abandonment and indicated that a patient will not be abandoned if a nurse rejects a patient assignment because of fatigue, illness or stress, if certain other conditions are met. ***Opposed***

HB 726 Added a representative of the Kentucky Association of Nonprofit Homes and Services for the Aging, Inc. to the Board of Nursing. ***Monitored***

HJR 149 Supported full formula funding of state - supported higher education and expansion of nursing education programs. ***Monitored***

SB 239 See under Indigent Care.

SB 251 Required all hospitals to provide, as a condition of licensure, an acuity based staffing plan in accord with staff/patient ratios established by this legislation; nursing supervisors and administrative personnel could not be counted in establishing the ratio; prohibited nurse work weeks in excess of 40 hours without consent; the bill also had a provision outlining when a nurse may refuse a patient assignment. ***Monitored***

SB 337 Required Council on Higher Education to close one Kentucky law school and convert it to a two-year school of nursing. ***Monitored***

SJR 44 **Encourages the Council on Higher Education to expand nursing programs. *Supported per Resolution W-1988 House of Delegates ADOPTED**

NURSING HOMES/LONG TERM CARE

HB 118 **Defines long-term care ombudsman and willful interference; provides that willful interference with LTC ombudsman is a Type B violation. *Monitored.* ADOPTED**

HB 158 **Creates a new section of KRS Chapter 216 to define boarding homes and requires the annual registration of boarding homes with CHR. *Monitored.* ADOPTED**

HB 342 **Requires the Commissioner of Insurance to annually compile a consumer's guide to LTC insurance; requires the Commissioner to distribute the guide free of charge. *Monitored.* ADOPTED**

HB 597 Permitted construction of LTC facilities limited to 100 beds in counties in which no facility is located; exempted such facilities from the CON process. ***Monitored***

HB 797 Permitted Medicaid payment of travel expenses for out-of-state trips taken by LTC administrators and owners under certain conditions. ***Monitored***

SB 265 See under Hospitals.

POLITICAL ACTION COMMITTEES

SB 145 **Prohibits candidates, committees or contributing organizations or anyone on their behalf from accepting a corporate contribution directly or indirectly; prohibits limiting a corporation's ability to administer its committee when actions are deemed as not influencing an election. *Supported.* ADOPTED**

PHARMACY/PHARMACEUTICAL COMPANIES

HB 101 In original form, this bill required that the diagnosis be placed on prescription containers. KMA worked with the sponsor to amend the bill permitting the patient to make a specific request to the physician that the symptom for which he or she is being treated be listed on the container. ***Monitored***

HB 102 **Requires out-of-state pharmacies which ship prescriptions into the state to have an "out-of-state pharmacy" permit. **Supported per Resolution K-1989 House of Delegates.* ADOPTED**

HB 112 **Makes it a Class C felony to: (1) possess or use an anabolic steroid without a valid prescription or drug order; (2) prescribe, order, etc., an anabolic steroid to enhance athletic performance, increase muscle mass, etc.; or, (3) manufacture, deliver, or possess with intent to manufacture or deliver, an anabolic steroid unless the person doing so is a licensed practitioner or a lawful manufacturer. *Supported.* ADOPTED**

HB 656 Created an offense under the controlled substance act for a person to contact or visit a number of physicians or other licensed practitioners for the purpose of obtaining controlled substances. ***Monitored***

HB 672 Allowed rather than required the dispensing of a generic drug substitute by a pharmacist who receives a prescription for a brand-name drug. ***Monitored***

HB 706 Added Schedule III drugs to the list of substances for which the illegal possession of is a felony. ***Monitored***

HB 803 Required licensure of drug manufacturers and wholesalers. ***Monitored***

SB 42 Defined drug-dependent person; specified how controlled substances are scheduled; required prescription records to be kept for five years rather than two years. ***Monitored***

SB 347 See HB 803 above.

PRACTITIONERS

HB 79 Required dental hygenists working without supervision of a dentist to have a dentist's prescription for treatment; required hygenists to have valid certificate of cardiopulmonary resuscitation. ***Monitored***

HB 86 ARNP prescribing - See under Nursing.

HB 285 **Requires underground coal mines employing 12 or more employees to employ one EMT; requires an additional EMT for each additional 50 employees. *Monitored.* ADOPTED**

HB 566 Deleted exemptions from licensing of social workers employed by the state and church organizations. Exempted such people so employed from examination until February 1, 1992 provided they met other requirements. ***Monitored***

HB 568 Authorized social workers board to conduct disciplinary hearings and permitted social workers to practice while awaiting examination period. ***Monitored***

HB 800 **Optometric Board Practice Act establishes method for hearing complaints; prohibits false advertising; raises licensing fee.** ***Monitored.*** **ADOPTED**

HB 873 Recognized chiropractor schools accredited by US Department of Education. ***Monitored***

HB 880 Allowed paramedics to work in hospitals in a non-emergency situation and enabled paramedics to transfer patients from hospital to hospital in non-emergency situations; provided for a hospital administrator to serve on Paramedic Advisory Committee. ***Opposed***

SB 136 **Requires respiratory therapists to be certified.** ****Supported per COSLA Report and Resolution N-1989 House of Delegates.*** **ADOPTED**

SB 239 Mid-Level Practitioners - See SB 239 under Indigent Care.

SB 348 Included various new criteria for the Board of Pharmacy to restrict licensing; permitted immediate suspension or revocation of a license by the Board for health, welfare, or safety reasons. ***Monitored***

SAFETY

HB 27 Related to driving under the influence; other bills introduced included HBs 122, 257, 276, 333, 435, 464, 567, 705, 794, 870; SBs 163, 183, 282, all relating to driving under the influence or reducing BAC necessary for a presumption of intoxication. None were adopted. ****Supported per COSLA Report-1989 House of Delegates***

HB 73 Contained requirements regarding minimum visual acuity and horizontal visual field diameter. ****Supported per COSLA Report 1983 & 1989 House of Delegates.***

HB 110/160 Prohibited passengers under 18 years of age from riding in an open-bed vehicle. ****Supported per Resolution BB-1989 House of Delegates.***

HB 315 Required school buses be equipped with emergency radio transmitting device. ***Supported per COSLA Report-1989 House of Delegates***

HB 414 Required driver's license renewal every four (4) years; established satisfactory completion of a vision test as a prerequisite to licensure. ***Supported per COSLA Report-1983 & 1989 House of Delegates***

HB 457 Broadened the child restraint requirements and created a mandatory seat belt requirement, established a $25 fine for violation. Stipulated that law enforcement officers cannot stop an individual solely because of seat belt violation. ***Supported per Resolution Y-1986 House of Delegates and Resolution K-1987 House of Delegates***

HB 490 Eliminated helmet requirements for motorcyclists over age 21 who completed a motorcycle rider education program. ***Opposed per long-standing position of KMA House of Delegates***

HB 769 Companion bill to HB 457 above except it had a $50 fine for violations.

SB 76 Established guidelines for drivers who see with aid of bioptic telescope. ***Opposed***

SB 158 **Requires All-Terrain Vehicle (ATV) operators to wear helmets; prohibits use of ATVs on any highway; limits operation of ATVs by children under 16 years of age without parental supervision; and prohibits operation by children under 12 when engine exceeds 70 cubic centimeters and under 16 when engine exceeds 90 cubic centimeters; prohibits use on private property without permission from owner.** ***Supported.*** **ADOPTED**

SB 261 Established a task force on bus safety. ***Supported per COSLA Report-1987 House of Delegates.***

STATISTICS

HB 64 **Vital statistics bill establishes birth definitions; designates a state and local registrar; birth certificate procedures; flags birth certificates of missing children; death certificates; coroner cases; disenterment procedures.** ***Supported with amendment.*** **ADOPTED**

HB 126 Established birth defect registry to collect and provide information about the incidents, causes and strategies to prevent birth defects, stillbirths and miscarriages. ***Monitored***

HB 492 Prohibited health care price discounting. This bill created the Department of Health Care Consumer Information and required hospitals and ambulatory facilities to report price and quality information regarding medical conditions and health care services. ***Monitored***

HB 636 Required treating physician, hospital administrator or designee, to report certain burns to the State Fire Marshall within 72 hours of the time treatment occurs. Contained confidentiality requirements and established reporting format; made failure to report a Class B misdemeanor. ***Opposed***

TOBACCO

HB 127 Forbade use of tobacco products on school grounds or buses. ****Supported per Resolution B-1989 House of Delegates***

HB 322 Provision in Governor's original budget proposal increased taxes on tobacco products from 3 cents to 10 cents. ****Supported per Resolution R-1989 House of Delegates***

HB 543 Increased cigarette taxes from 3 cents to 10 cents. ****Supported per Resolution R-1989 House of Delegates***

HB 627 Prohibited sale of tobacco to children under age 16. ****Supported per Resolution C-1989 House of Delegates***

HB 628 **Prohibits the sale of tobacco products to anyone under the age of 16. Also requires that signs be posted concerning this prohibition. Other provisions, called smokers' rights, prohibit employment discrimination against smokers or any requirement that a smoker abstain from tobacco use outside the course of employment. **Supported per Resolution C-1989 House of Delegates.*** ADOPTED

TORT REFORM

HB 410 Regulated risk-retention groups. ***Supported***

HB 553 **This legislation will provide for a full statutory protection of "qualified retirement plans" from judgment and, also, exclude "qualified retirement plans" from the estate in the event of bankruptcy. To receive the protection, the retirement plan must qualify under the applicable provisions of the Internal Revenue Code of 1986 which has certain minimum requirements and caps as to the amount which can be contributed into the retirement plans. The status of the law in Kentucky prior to enactment of HB 553 would allow protection of pension plans only to the extent the**

funds were reasonably necessary for the debtor to survive. The pre-HB 553 law provided no specific standards for determining the appropriate amount to be exempt, and each court would make its decision on factors it believed to be important in that particular case. Usually, this resulted in the debtor's entire pension benefit being consumed by creditors. Courts have attached the pension benefits of teamsters, physicians, insurance agents, nurses, factory workers, retail clerks, and others, many of whom lost pension benefits after completing much of their working lives.

HB 553 will not protect a "qualified pension plan" in the event of either an order of the court for payment of maintenance or an order of a court for payment of child support. Also, if a contribution is made to a "qualified retirement plan" within 120 days of a debtor filing for bankruptcy, that particular amount contributed would not be protected from creditors. With the enactment of HB 553, the assets in "qualified retirement plans" for all individuals across the Commonwealth will be protected from judgment. *Supported per Resolution EE-1988 House of Delegates. ADOPTED

HB 602 Created a general physician/patient privilege in Kentucky, which does not now exist per statute or common law. This privilege protected a patient's records even if the physician received a subpoena. Provided for certain situations where the privilege would be waived by the patient. ***Supported***

HB 657 **Re-enacts the confidentiality of peer review provision which was struck down by the Kentucky Supreme Court in Sweasy v. King's Daughters Memorial Hospital. The high court noted the constitutional requirement that "no law enacted by the General Assembly shall relate to more than one subject, and that subject shall be expressed in the title." HB 657 protects peer review records by establishing the records as privileged and confidential. Persons applying for or granted staff privileges waive any claims for damages involving peer review activities which were conducted in a good faith manner. Peer review activities shall be confidential and not subject to discovery. However, the protections do not restrict or limit the right to discovery or use in a civil action any evidence, document or record which is subject to discovery independently of the proceedings of the peer review committee, board, etc. Other provisions relate to testimony as to opinions formed in reaching a peer review decision. *Supported.* ADOPTED**

HB 822 Extended immunity from civil liability to volunteers in the health care and governmental areas. ***Monitored***

SB 182 **Amends one of the measures contained in HB 552, the insurance regulatory portion of KMA's 1988 liability package. Permits 14 days to pay premium before cancellation for "non-payment" of premium takes place. However, the provision requiring 75 days' notice prior to cancelling a policy is retained.** ***Monitored.*** **ADOPTED**

SB 192 Amended Section 54 of the Kentucky Constitution to allow the General Assembly to limit recovery in tort for non-economic loss and to prescribe the manner in which damages shall be paid. ****Supported per Ad Hoc Committee on PLI-1989 House of Delegates***

SCR 91 **Requires a study of court costs, their origin, revenues generated, and object for which spent.** ***Supported.*** **ADOPTED**

SCR 95 Directed the Legislative Research Commission (LRC) to appoint a task force to study alternative methods of dispute resolution and more efficient ways to deal with conflicts, including complex matters now dealt with only by our judicial system. ****Supported per Ad Hoc Committee on PLI-1989 House of Delegates***

WORKERS' COMPENSATION

HB 147 **Provides for a co-chairman of the Workers' Compensation Advisory Council.** ***Monitored.*** **ADOPTED**

HB 149 **Provides 45-day time period in which claimant may name the special fund a party in a workers' compensation case.** ***Monitored.*** **ADOPTED**

HB 150 **Clarifies that the 50-50 apportionment in workers' compensation special fund cases only applies to permanent disability.** ***Monitored.*** **ADOPTED**

HB 151 **Prohibits settlements unless all partners agree.** ***Monitored.*** **ADOPTED**

HB 459 **Requires party requesting medical exam of a workers' compensation claimant pay exam cost.** ***Monitored.*** **ADOPTED**

HB 647 Deleted requirement to file a Federal black lung claim. ***Monitored***

HB 735	Changed references in present law of workers' compensation. ***Monitored***
HB 840	**Removes the $6500 cap on attorney fees in initial cases and the $3250 fee on reopened cases. *Monitored.* ADOPTED**
HB 867	Declared unfair trade practice for health insurer to exclude coverage for work-related condition unless claimant is eligible for workers' compensation. ***Monitored***
HB 907	Eliminated cap on attorney's fees in initial and reopened workers' compensation cases. ***Monitored***
HB 908	Authorized administrative law judge to rely on the best, rather than the largest, spirometric test values in determining the presence or extent of coal-related occupational pneumoconiosis. ***Monitored***
SB 61	**Deletes rehabilitation panel. *Monitored.* ADOPTED**
SB 62	**Requires the use of the latest edition available of the AMA guides in workers' compensation cases. *Supported.* ADOPTED**
SB 92	**Confirms the reorganization of the Department of Workers' Claims within the Labor Cabinet. *Monitored.* ADOPTED**
SB 333	**Specifies that employers or their insurers are liable for the costs of rehabilitation. *Monitored.* ADOPTED**

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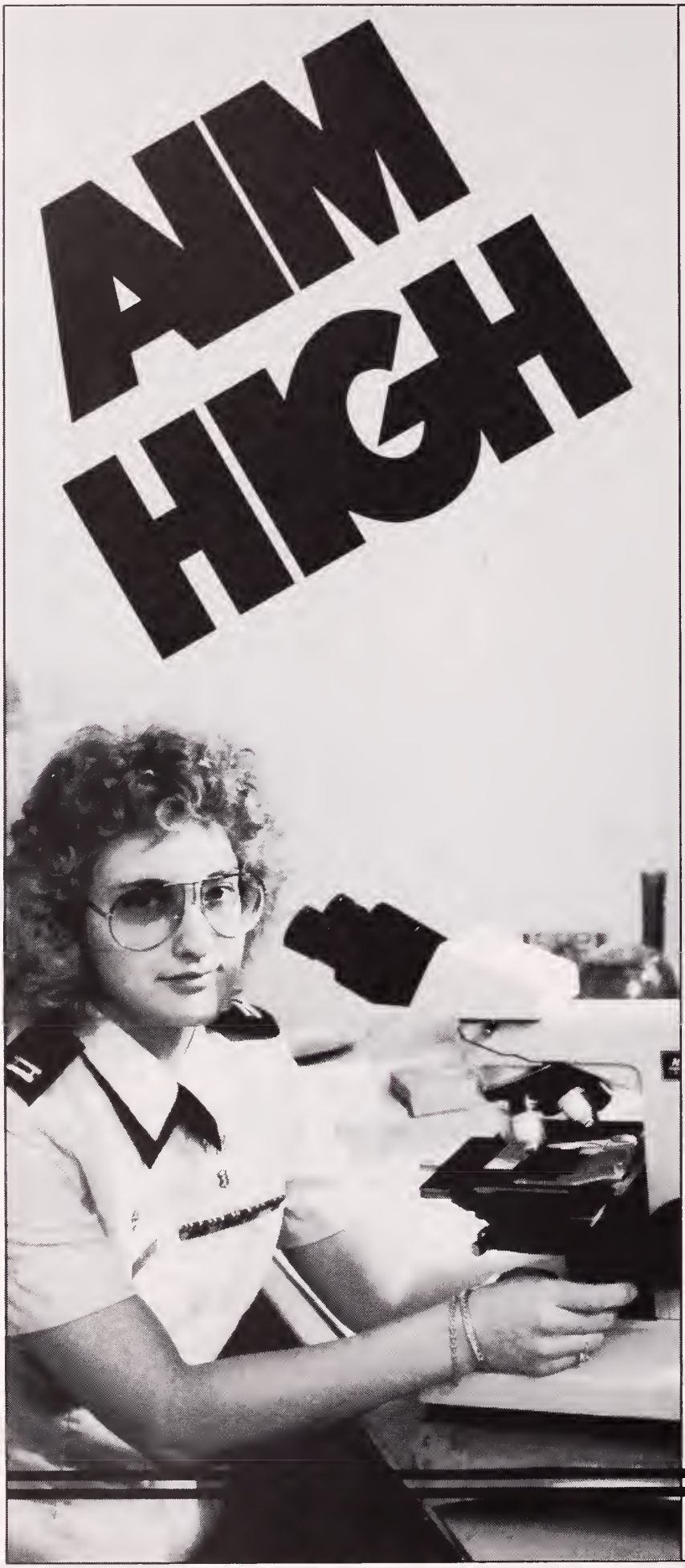

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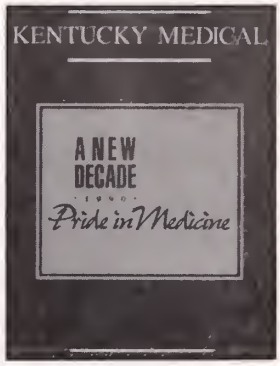

COVER: The KMA 1990 Annual Meeting logo introduces a special Annual Meeting Section beginning on page 409. Design by Linda Fortwengler.

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References

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4. Scand J Gastroenterol 1987;22(suppl 136):61-70.
5. Am J Gastroenterol 1989;84:769-774.

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In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

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Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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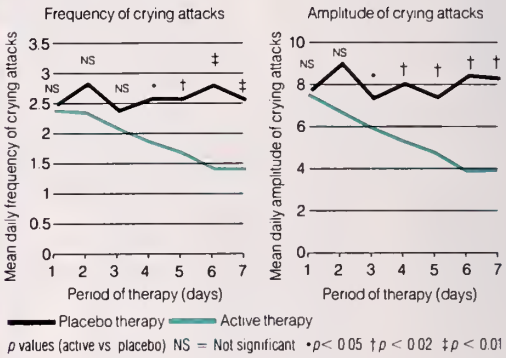

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Reflections on the 1990 *KBA* Conventions

'Never before had I been so aware of the fact that, lawyers jokes aside, like it or not, our two professions are irrevocably bound in deciding some of the most important ethical and economical issues in the future of the practice of medicine. . . . The courts may well make many of these decisions for us.'

The 1990 Kentucky Bar Association Convention and Judicial Conference was held June 13-16 in Lexington. It was a broad-based continuing legal education program with a variety of speakers, including F. Lee Bailey and Richard Dysart, who plays "Leland McKenzie" the older "ethical" attorney on TV's popular "L.A. Law." It was an historical occasion for Kentucky medicine. For the first time ever as a part of a *legal* continuing education program, physicians were asked to participate — no, not as expert witnesses, but as fellow professionals dealing with an area of mutual concern, "Ethical Issues Facing Medicine: Common Issues for the Physician and the Attorney." It was not a simple undertaking. Mr Billy J Mabry, KMA's Director of Legal and Governmental Relations, who coordinated the project and acted as program chairman, began working on this in January 1990.

I was pleased to represent the KMA as its President and spoke concerning several pressing ethical issues we face daily as practicing physicians. Some of these were discussed on the "President's Page" in the November 1989 *Journal of the KMA*. We touched upon the history of medical ethics including the new field of *biomedical ethics* as well as the age-old field of *clinical medical ethics*. Other issues mentioned were the escalating costs of medicine, including their *legal* components such as costs of malpractice, insurance premiums, and the necessity to practice "preventive medicine." The ever-expanding body of regulations, restrictions, and practice parameters which bind us were discussed as the "hassle factor" in medicine. Pertinent social issues discussed and the medical and legal dilemmas they involve included: abortion and problems in human reproduction such as in-vitro fertilization, "surrogate motherhood," frozen embryos, sperm banks, and fertility drugs. Genetic manipulation, the AIDS epidemic, euthanasia, doctor-assisted suicide, indigent care, the issues of death and dying, and the prospects of limiting care by rationing were all

'Having the liaison thrust upon us, I feel we as a profession must do our best to become informed and to cooperate in making those decisions within the laws of this nation and our Commonwealth which will best help our patients.'

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By coincidence, the 1990 logos for the Kentucky Medical Association and the Kentucky Bar Association were similar.

mentioned. More importantly, we explained that our society's expectations of the health care system and what we can deliver in the face of diminishing resources are not always compatible. There is no doubt, we told them, that advanced technology has given us the ability to prolong life, but all too often, not to enhance its quality. The AMA's and KMA's policy *against* physician-assisted suicide was reinforced, and the ancient rule for this was quoted, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel," HIPPOCRATES, 5TH CENTURY B.C.

The issues of organ transplantation and death and dying were discussed with great insight and sensitivity by Dr William L. DeVries, well-known Louisville cardiovascular surgeon, who performed the world's first artificial heart transplant. His series of slides of the artificial heart patients and their families are poignant reminders of the use of the Jarvick-7 and its effects on the lives of these people. The legal issues he faced in doing these procedures were com-

'He expressed great concern over ever-increasing governmental control and the ability to continue research leading to technology in the face of constant expanded budget cuts and legal constraints. He predicted the 1990s will not see as much technological progress as did the 1980s.'

plex, frustrating, and in some instances, dominated clinical decision making. His personal involvement with these patients and their families was obvious. He expressed great concern over ever-increasing governmental control and the ability to continue research leading to technology in the face of constant expanded budget

'Conflicts in treating the indigent under COBRA (Consolidated Omnibus Reconciliation Act of 1985), the problems of the uninsured, and the practice of "patient dumping" of the indigent were also discussed.'

cuts and legal constraints. He predicted the 1990s will not see as much technological progress as did the 1980s.

Billy J. Mabry's discussion included the ethical issues of confidentiality in the physician-patient relationship, specifically in the treatment of AIDS patients and the impact of HB425, the "Mason AIDS Bill," as it relates to testing for HIV and reporting AIDS cases. Conflicts in treating the indigent under COBRA (Consolidated Omnibus Reconciliation Act of 1985), the problems of the uninsured, and the practice of "patient dumping" of the indigent were also discussed.

The other attorney on the panel was Mr Stuart McCloy, Assistant Attorney General of Kentucky, and Chief of the Medicaid Fraud and Control Division. He dealt with various "business deals" entered into by physicians and some of the possible consequences, and of the murky area of "Safe Harbors." He addressed the new "Living Will" legislation which went into effect in Kentucky July 13, 1990, including the provision for appointing a surrogate health care decision-maker. He also discussed the appointment of a guardian where necessary, as well as the responsibilities of a "Durable Power of Attorney." He dealt with the very controversial issues surrounding "Right to Die" such as "types of medical interventions that can be legally withheld or withdrawn."

Never before had I been so aware of the fact that, lawyers jokes aside, like it or not, our two professions are irrevocably bound in deciding some of the most important ethical and economical issues in the future of the practice of medicine. As resources become more and more limited, we face hard choices as to whom we may treat, how we may treat them, and who is going to pay for this treatment. The courts may well make many of these decisions for us. I do believe very strongly that the American justice system, as well as the American health care delivery system, with all their faults, are the finest in the world. Having the liaison thrust upon us, I feel we as a profession must do our best to become informed and to cooperate in making those decisions within the laws of this nation and our Commonwealth which will best help our patients.

The necessity for the two professions to exchange their thoughts and common concerns was emphasized by the current American Bar Association President Stanley L. Chauvin, Jr, Esq, of Louisville, when he addressed the AMA Annual Meeting in Chicago in June. Mr Chauvin and Allen Nelson, MD, AMA President, shared in a mutual concern earlier this year when they visited with many school-age children in a joint educational effort on the effects of drug usage and dependency. We endorse this collaborative effort with the legal profession.

'The AMA's and KMA's policy against physician-assisted suicide was reinforced, and the ancient rule for this was quoted, "I will give no deadly medicine to anyone if asked, nor suggest any such counsel."
HIPPOCRATES, 5TH CENTURY B.C.'

I sincerely hope future cooperative efforts, such as this panel, will be made to aid both professions to deal with the many challenges and changes of this new era.

Nelson B. Rue, MD
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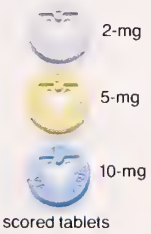

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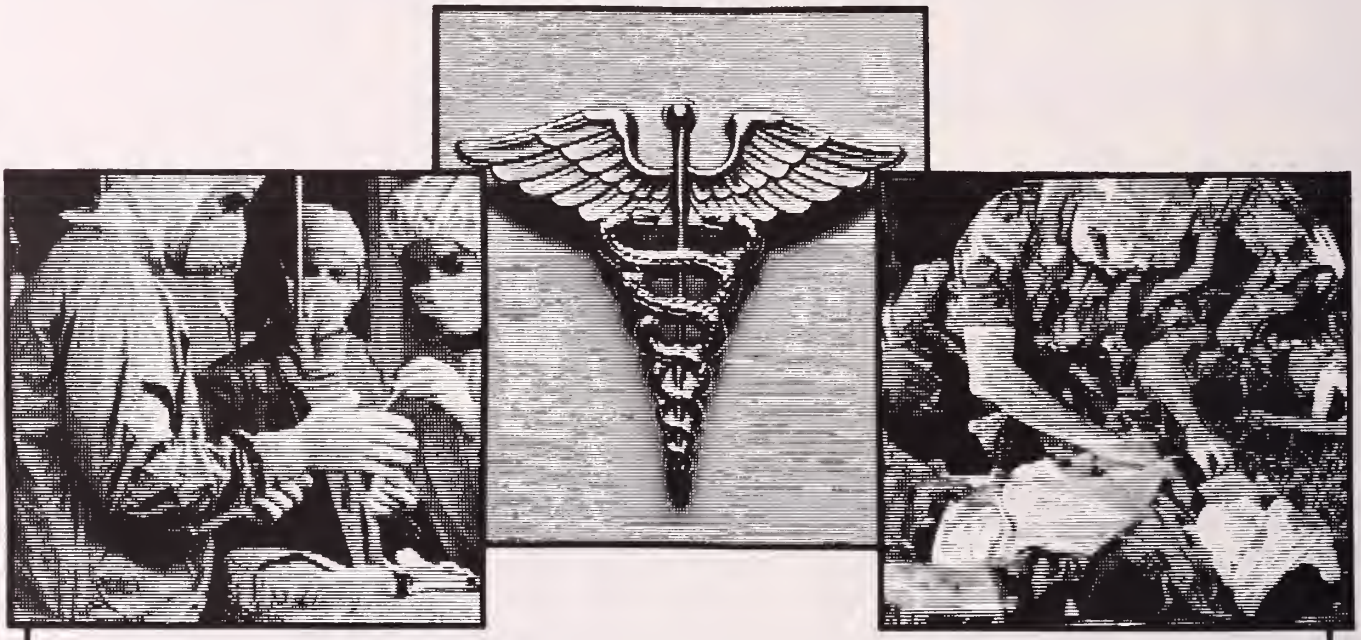

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Brucellosis: An Unusual Cause of Fever in Kentucky

Rachel Dotson, MD; Sean M. Maguire; Julie Hayden, MD; Amy Larsen; Sohail Ikram, MD

Human infection with brucellosis appears to be very uncommon in Kentucky. Only three cases have been reported to the Kentucky Department of Health, Frankfort, in the last 4 years. It is suspected, however, that brucellosis is severely underdiagnosed and under-reported in the United States.[1,2] A patient recently diagnosed with acute systemic brucellosis reminds us that this illness may still be seen in the Commonwealth.

From the Department of Internal Medicine, University of Louisville School of Medicine, 550 South Jackson St, Louisville, KY 40292.

Introduction

In the United States, brucellosis is a rare infection that is largely an occupational risk for people who work with domestic animals and their products. Less than 200 cases have been reported each year from 1983 through 1986, resulting in an annual incidence of 0.4 to 0.9 cases per million population.[3]

Importantly, epidemiologic data suggest that for each case recognized, there are 26 cases of brucellosis that are misdiagnosed or underreported.[1,4]

We report a patient recently diagnosed with systemic brucellosis to remind the clinician of the protean manifestations of this infection. A review of the recent medical literature is provided regarding the current suggested treatment for the acute manifestations and the potential complications of brucellosis.

Case Report

CK, a 50-year-old male, was admitted to the medicine service of the VAMC, Louisville, Kentucky, with complaints of generalized malaise, anorexia, nausea, daily fevers, chills, and sweats. He had diffuse myalgia and a persistent frontal headache. For the two weeks prior to admission, the patient was bedridden because of severe weakness. He also complained of insomnia and was unable to sleep for intervals of 72 to 96 hours.

The patient resides in western Kentucky and worked on a farm tending livestock. When questioned regarding exposure to animals that had been ill, the patient volunteered that the cattle he had cared for this year had recently been destroyed at the direction of the local veterinarian. Although the patient denied any ingestion of their meat or milk, he had been involved in their daily care and had been exposed to their blood and bodily fluids. The patient's wife, children, and fellow workers were in good health.

The patient has a 75 pack-year history of cigarette smoking and underwent resection of a malignant melanoma from the left scapular area in 1983. Continuous surveillance has been maintained through the clinics at the VAMC, without evidence of recurrence. The patient could recall numerous tick bites through the course of the summer.

The patient was found to be an acutely ill-appearing, thin white male who was alert and oriented. His oral temperature was recorded at 101.1°F and he was diaphoretic. The other vital signs were unremarkable. No lymphadenopathy was found. The patient's liver was enlarged to 15 cm in the right midclavicular line and his spleen was easily palpated 4 cm below the left costal margin. Moderate tenderness was present in both upper quadrants. No rashes or skin lesions were present. No focal lesions were present on the neurologic examination.

The patient's white blood count was 4,100 with 50% granulocytes, 39% lymphocytes, 7% monocytes, and 4% basophils. The platelet count was normal at 219,000. The electrolyte series, the urinalysis, and room air arterial blood gases analysis were normal. Serum alkaline phosphatase was elevated to 208 IU, SGOT to 60 IU, and the LDH to 1038 IU. Chest radiograph and bone scan done on admission were interpreted as normal.

Because of the patient's clinical presentation and history of exposure to sick livestock, agglutination titers for brucellosis were obtained. Blood cultures were drawn and the laboratory was notified to keep the blood samples for 3 to 4 weeks, as well as to exercise caution with the microbiologic samples because brucellosis was suspected.

Therapy was started with doxycycline 200 mg

and rifampin 600 mg daily. Five days after therapy was started, the patient became afebrile. His clinical improvement continued and he was discharged on the ninth hospital day with plans to continue the antibiotics in conjunction with weekly clinic examinations. Two days after his discharge, the agglutination titer for *Brucella abortus* was reported by the VA Reference Laboratory in Lexington, Kentucky, as positive at 1:2560. One week after discharge (3 weeks after submission), the blood cultures obtained on admission were reported to be growing brucellar organisms. The patient finished 6 weeks of therapy with doxycycline/rifampin and has enjoyed complete resolution of his clinical symptoms.

Discussion

Brucellosis, a zoonotic infection caused by a gram-negative, nonmotile coccobacillus, is characterized by fever, generalized malaise, chills, myalgia, headache, and anorexia. Human infection can be caused by any one of four species, each of which has a special predilection for infecting a specific animal host. This feature is of extreme importance to the clinician who is faced with a febrile patient presenting with nonspecific somatic complaints.

B. abortus (cattle) and *B. suis* (hogs) are responsible for the majority of brucella infections diagnosed in the US. Such infection is generally confined to farmers, veterinarians, livestock producers, and slaughterhouse employees. *B. melitenis* (goats) is almost always associated with the ingestion of dairy products made from unpasteurized goat's milk. *B. canis* (dogs) may rarely infect lab personnel and veterinary workers. Although less common in North America than in other parts of the world, the infection caused by *B. melitensis* is thought by most investigators to be more severe than the illness produced by the other species.[2]

Invasion of the human body may occur by several routes. The bacteria may cross the gastrointestinal mucosa after ingestion, transverse the respiratory mucosa after inhalation, or invade abraded skin lesions or the conjunctiva.

The patient's clinical presentation coupled with the serological and microbiological findings provide a classification system for brucellosis.[5] The "bacteremic" type features patients who are acutely ill and who have high brucellar agglutination titers and positive blood cultures for brucellar organisms. The "serologic" type includes those patients with systemic manifestations and high agglutination titers, but whose cultures for brucellar organisms are negative. Patients with the "localized" type rarely have systemic symptoms. Instead, their clinical presentation is predominantly that of the organ system involved. Although blood agglutination titers are low, high titers are found in specific body tissues or fluids. While the blood cultures will be uniformly negative in the "localized" type, brucellar organisms may be cultured from the involved organ. Finally, in "mixed" types, some combination of the above presentations occurs.

Acute brucellosis usually presents after 1 to 3 weeks of incubation. The patient's major complaints are fever, chills, lethargy, headache, arthralgia, myalgia, and low back pain. In some patients, cough, anorexia and weight loss occur. The major presenting signs are hepatosplenomegaly (41%), arthritis (26%), splenomegaly alone (20%), and lymphadenopathy (6%).[6] Interestingly, the majority of patients (72%) will have a normal white blood cell count and only 9% will have a leukocytosis. The erythrocyte sedimentation rate is usually elevated modestly and anemia is uncommon. Abnormal liver function is common in the acute presentation and is documented by mild elevation of the hepatic enzymes.

Definitive diagnosis by isolation of the brucellar organism occurs in only 15% to 20% of all cases. It may take 3 to 4 weeks before cultures become positive. The clinician must alert the laboratory to hold culture material for the adequate length of time if brucellosis is suspected. When this extra growth time is allowed, 50% of patients with acute brucellosis will have positive blood cultures. It should be recognized that even positive blood cultures can cause special problems for automated blood culture systems because the organism's metabolism of substrate amino acids and carbohydrates is often too slow to exceed a positive value. This problem can be overcome by interested laboratories by manual examination of the culture when stained with acridine orange. It is also essential the laboratory be notified whenever brucella infection is suspected so that special care can be taken to protect employees handling the specimens.[4]

The majority of infections are diagnosed by serologic methods. The most readily available and most commonly employed serologic test is the Brucella agglutination test which determines the presence of antibodies against brucellar antigens. A single titer of 1:160 or higher, or a fourfold or

greater rise in titer indicates recent infection. Cross reactions can be seen with *Vibrio cholera, Francisella tularensis,* and *Yersinia enterocolitica* which can cause false positive agglutination. The more recently available ELISA test offers the clinician a more sophisticated assay which offers profiles of the immunoglobulin (Ig) classes. The ELISA test can also be used on CSF, synovial fluid, and pleural fluid.[7]

Treatment guidelines are outlined by the World Health Organization based on antibiotic studies done in Middle Eastern countries where brucellosis is endemic. Since 1986, a single morning dose of doxycycline (200 mg) and rifampin (600-900 mg) daily for 3 to 6 weeks has been recommended as 98% effective, with a relapse rate of only 1% to 2%.[8] In the majority of patients treated with this combination of antibiotics, fever dissipates after 5 to 7 days of treatment.

Selection of alternate or additional agents for treatment may be indicated in the presence of complications which occur in 10% to 15% of infected patients. Since brucella disseminates via the bloodstream, the organism has the potential to involve virtually any organ system.

Bone and joint disease is the most common complication of brucellosis. Brucella arthritis is usually monoarticular and associated with joint swelling, favoring the sacroiliac, hip, and knee joints. The frequency of isolation of the brucella organism from the synovial fluid is reported at approximately 60%.[9] There is some evidence that a type of nondestructive arthritis with sterile synovial effusions is equally common and resembles a "reactive arthritis" mediated by circulating immune complexes.

Actual infection of the bone, osteomyelitis, has been described. The spine is the site most commonly involved, and the patient's symptoms are local pain, tenderness, and fever. The organism is difficult to culture, but investigators have greater success with tissue culture than joint fluid culture. A high or rising agglutination (or ELISA) titer is considered confirmatory in a patient in the correct clinical context. Treatment of joint and bone infections includes aggressive surgical drainage except for those infections involving the spine, coupled with 3 weeks of double antibiotic therapy. Relapse rates for skeletal involvement with such therapy range from 10% to 15%.[10]

Neurologic complications of brucellosis occur in 5% to 10% of infected patients. There may be nonspecific neuropsychiatric sequelae such as headache and acute confusion that occur in patients with the systemic forms of the disease and are attributed to the acute toxic-febrile state. Also, disease may occur from actual invasion of the central nervous system due to the direct effect of brucella organism or its endotoxin. The presentation is most commonly that of acute, chronic, or recurrent meningoencephalitis. Involvement of one or more cranial nerves commonly occurs with basal meningeal involvement and the eighth nerve is the most frequently involved. Likewise, myeloradiculopathy may occur from infectious arachnoiditis of the spinal cord or from infectious vasculitis with medullary infarcts.

Although the CSF analysis may show a lymphocytic pleocytosis, an elevated protein and low CSF glucose, these findings are nonspecific. CSF culture for brucellar organisms is positive only 50% of the time. Neurobrucellosis is confirmed most commonly by the standard agglutination test or the recently available ELISA assay. The outcome of treated neurobrucellosis is generally favourable despite the potentially protracted course of the disease. Rifampin and doxycycline should be continued for at least 4 months in order to avoid relapse. Corticosteroids are often added in the early stages of treatment.[6, 11]

Approximately 6% of patients with brucellosis develop cutaneous lesions which are most typically disseminated, erythematoviolaceous papulonodular lesions, affecting the lower extremities.[12] Usually these lesions clear within the first 7 days of therapy and only rarely are culture positive for brucellar organisms.

Cardiovascular complications can occur in 2% of infected patients and remains the most lethal localized involvement. Cardiac infection is usually manifest as subacute bacterial endocarditis. Native aortic and mitral valves are involved with equal frequency. Successful response to combination antibiotic therapy is usually curative and valve replacement is not absolutely necessary. The treatment of Brucella endocarditis, however, requires the addition of an aminoglycoside to the doxycycline/rifampin regimen.[13, 14]

Respiratory complications from brucellosis are distinctly uncommon and occur in less than 1% of infected patients.[6]

In summary, brucellosis is an unusual but potentially curable infection with currently available antibiotics. The acute infection, as well as chronic complications, can be resolved when the diagnosis is suggested by the major clinical clues in a well-taken medical history.

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Disorder of Excessive Daytime Somnolence: A Case Series of 1,000 Patients

Walter E. App, MD; George W. Boatwright, MD; Suzanne E. Ostrander, BA; Marilee M. Unruh, RPSGT; David H. Winslow, MD

Symptoms of excessive daytime somnolence range from mild to severe. In mild cases, there may be minimal interference with normal daytime function. The hypersomnia can be disabling. When severe the patient finds it difficult to remain awake at times when physically inactive. Excessive daytime somnolence is the chief complaint of the majority of our adult patients.

In this paper, we present the findings for 1,000 consecutive patients (755 males and 245 females) who were seen at the Humana Hospital Audubon Sleep Disorders Center. Patients ranged in age from 15 to 83. All patients had a sleep history, medical history and physical, psychological evaluation, polysomnographic evaluation, and other laboratory tests as indicated.

Obstructive sleep apnea syndrome was the most prevalent diagnosis for males (84.2%) and females (59.6%). It accounted for over three-fourths of all diagnoses. Hypersomnia secondary to a psychiatric disorder was the next most frequent diagnosis overall (6.1%). A psychiatric disorder was second for females and third for males. Narcolepsy was diagnosed for 5.8% of all patients. This was the second most prevalent diagnosis for males and third for females. Eighteen males (47.4% of all males with a diagnosis of narcolepsy) and 9 females (45.0%) had cataplexy. Nocturnal myoclonus was the primary diagnosis in 2.5% of all patients with excessive daytime somnolence. An additional 49 patients with sleep apnea syndrome and 18 patients with narcolepsy also had periodic leg movements during sleep. A diagnosis of obstructive sleep apnea and narcolepsy was made for 1.3% of patients. The narcolepsy component of this diagnosis was typically made only after the obstructive sleep apnea had been resolved (eg, nasal CPAP, tracheostomy). Cataplexy was reported by 6 males (75.0%) and 2 females (40.0%). Periodic leg movements were observed in 4 patients with a diagnosis of sleep apnea and narcolepsy. Eight cases (0.8%) were classified as insufficient nighttime sleep and 7 cases (0.7%) as hypersomnia secondary to other medical condition (eg, COPD). Idiopathic CNS hypersomnia was diagnosed for 7 patients (0.7%). Drug use was the primary diagnosis in 3 patients (0.3%). Thirty-six patients (3.6%) complaining of excessive daytime somnolence did not show any objective pathological findings after completing their diagnostic testing.

Obstructive sleep apnea syndrome is by far the most common diagnosis for our patients. For approximately one-fourth of patients, however, the diagnoses are quite diverse. These findings point to the need for a comprehensive evaluation program for any patient who presents with a chief complaint of excessive daytime somnolence.

From the Sleep Disorders Center, Humana Hospital Audubon, and Department of Medicine (Dr Winslow), University of Louisville School of Medicine. Reprint requests to Dr Winslow, Humana Hospital Audubon, Louisville, KY 40217.

Methods

The case series consisted of 1,000 consecutive patients (755 males and 245 females) who were seen at the Humana Hospital Audubon Sleep Disorders Center. All patients presented with a complaint of excessive daytime somnolence. Patients ranged in age from 15 to 83.

All patients underwent a three-part assessment. This consisted of an initial evaluation, polysomnography, and other testing as indicated. The initial evaluation included an interview with a sleep disorders specialist, medical history, physical examination, a sleep-wake questionnaire, and psychological screening (typically the MMPI and Beck Depression Scale). A decision was made concerning further diagnostic testing following completion of the initial evaluation. For this report, all patients subsequently had an all-night polysomnographic (NPSG) evaluation. The NPSG consisted of continuous monitoring of the electroencephalogram (EEG), submental electromyogram (EMG), electro-oculogram (EOG), electrocardiogram (ECG), EMGs from the right and left anterior tibialis muscles, abdominal and thoracic ventilatory effort, nasal-oral airflow, and arterial blood oxygen saturation. Other measures (eg, gastroesophageal pH) were also monitored during sleep as indicated. The NPSG was scored in 30-sec epochs according to standardized criteria.[1-3] The multiple sleep latency test (MSLT)[4] was completed the next day by 734 patients. The

MSLT consisted of four or five nap sessions. Trials were conducted at 2-hr intervals. The EEG, submental EMG, EOG, and ECG were monitored at each MSLT session. The third component of the workup included other evaluations as indicated (eg, thorough psychiatric assessment).

The final diagnosis for each patient was based on a review of all findings by a team of physicians who routinely evaluate patients with a sleep disorder. A board certified sleep disorder specialist was involved in formulating a diagnosis for each patient based on established nosology.[1]

Minimal criteria for diagnosis of sleep apnea syndrome includes multiple obstructive or mixed apneas during sleep associated with repetitive episodes of loud snoring and excessive daytime sleepiness (EDS).

A psychiatric diagnosis was made when no physiologic reasons for EDS was found and clinical and psychologic screening tests were consistent with depression or other psychiatric illness.

Narcolepsy was based on the typical findings of excessive daytime sleepiness based on multiple sleep latency and abnormal manifestations of REM sleep. The latter includes frequent sleep onset REM periods which may be subjectively appreciated as hypnagogic hallucinations, cataplexy, or sleep paralysis. All other causes of EDS were excluded before the diagnosis of narcolepsy was made. In patients with sleep apnea and signs of narcolepsy the sleep apnea was first eliminated with nasal CPAP before repeat testing was done to confirm narcolepsy.

Nocturnal myoclonus was based on highly stereotypical abrupt contractions of leg muscles during sleep causing frequent arousal and a complaint of EDS.

Insufficient sleep was diagnosed when the history clearly suggested inadequate sleep time and the problem was corrected by adequate sleep.

If no reason for EDS was found after complete testing but an underlying disease was present, ie, severe COPD or arthritis, we diagnosed other medical conditions as the cause of EDS.

In the face of no findings other than EDS, based on a MSLT score of 5 minutes or less and the absence of sleep onset REM periods the diagnosis of idiopathic hypersomnia was made. These patients were all getting adequate sleep at night and had negative urine drug screens.

The three patients with EDS due to drug use all had positive urine cocaine metabolites.

If patients complained of EDS but no physiologic or psychologic reason was found along with a normal multiple sleep latency test, we diagnosed no objective findings.

To assess the validity of the diagnoses made at the Sleep Disorders Center, ten patients (1% of total) were randomly selected. The charts for these ten patients were then sent to an outside physician board certified in sleep medicine for an independent verification of the diagnosis. The independently determined diagnosis was identical to that made at the Sleep Disorders Center for all patients.

Results

Obstructive sleep apnea syndrome is the most prevalent diagnosis for males (84.1%) and females (59.6%). It accounts for more than three-fourths of all diagnoses for patients with a disorder of excessive daytime somnolence. These data are presented in Table I. Snoring is the primary additional symptom in making a presumptive diagnosis of obstructive sleep apnea.

Hypersomnia due to a psychiatric disorder is the second most frequent diagnosis overall. It is second for females (11.4%) and third for males (4.4%). Within this diagnostic category, an affective disorder accounts for 86.9% of all cases. Patients with a diagnosis of a psychiatric disorder are without evidence of a concomitant physiologic etiology.

Narcolepsy is the third most prevalent diagnosis. Narcolepsy is second for males (5.0%) and third for females (8.2%). While cataplexy is pathognomonic in making a presumptive diagnosis of narcolepsy in patients with excessive daytime somnolence, only 18 males (47.4% of all males with a diagnosis of narcolepsy) and 9 females (45.0%) report cataplexy. This is consistent with other case series of narcoleptics which have shown that approximately half of the patients have cataplexy.[5]

Thirteen patients are diagnosed with obstructive sleep apnea and narcolepsy. Such a diagnosis is difficult to make. In the presence of sleep apnea, REM sleep during the MSLT is not considered diagnostic of narcolepsy. Thus, although patients with sleep apnea in this diagnostic category have REM onsets during the MSLT, these abnormalities could be secondary to the disrupted REM at night during which the apnea is generally most severe. The narcolepsy component of this diagnosis is typically made only after the obstructive sleep apnea has been resolved. The current standard

Table I. Primary Diagnosis for 1,000 Consecutive Patients Evaluated for a Disorder of Excessive Daytime Somnolence

	Male		Female		Total	
Primary Diagnosis	N	%	N	%	N	%
Sleep Apnea Syndrome	635	84.1	146	59.6	781	78.1
Psychiatric Disorder	33	4.4	28	11.4	61	6.1
Narcolepsy	38	5.0	20	8.2	58	5.8
Sleep Apnea Syndrome and Narcolepsy	8	1.1	5	2.0	13	1.3
Nocturnal Myoclonus	15	2.0	10	4.1	25	2.5
Insufficient Sleep	4	0.5	4	1.6	8	0.8
Other Medical Condition	3	0.4	4	1.6	7	0.7
Idiopathic Hypersomnia	5	0.7	2	0.8	7	0.7
Drug Use	3	0.4	1	0.4	4	0.4
No Objective Findings	11	1.5	25	10.2	36	3.6

therapy and completely efficacious treatment of sleep apnea is nasal continuous positive airway pressure (CPAP).[6] If the patient with sleep apnea has excessive daytime somnolence which persists after using nasal CPAP for 1 to 2 months, the patient should be reevaluated to determine if narcolepsy is present. A history of cataplexy is also an indication for reevaluation with polysomnography on nasal CPAP to rule out narcolepsy. Cataplexy is reported by six males (75.0%) and two females (40.0%) in this diagnostic category.

Nocturnal myoclonus or periodic leg movements during sleep is a relatively infrequent primary diagnosis. It accounts for 2.5% overall. Nocturnal myoclonus is more typically associated with insomnia.[7] However, 49 patients with obstructive sleep apnea (6.3%), 18 patients with narcolepsy (31.0%), and 4 patients with sleep apnea and narcolepsy (30.8%) also have nocturnal myoclonus. Periodic leg movements during sleep are often observed in patients with narcolepsy, but the clinical significance of nocturnal myoclonus in patients with sleep apnea is unknown. This condition should be a treatment consideration if the patient with obstructive sleep apnea and nocturnal myoclonus continues to have pathological daytime somnolence after the apnea has been resolved.

Insufficient nighttime sleep is diagnosed in eight patients. Patients in this diagnostic category complain of daytime somnolence, have a relatively short typical total sleep time, have normal sleep on polysomnography, and are without other significant clinical findings. Patients fail to realize the need for 7.5 to 8 hours of sleep per night. Hypersomnia associated with other medical conditions accounts for seven diagnoses. Chronic obstructive pulmonary disease is the most prevalent diagnosis (42.9% of patients) with other pulmonary and neurologic conditions making up 14.3% and 42.9%, respectively.

Idiopathic CNS hypersomnia is the major diagnosis in 0.7% of patients with excessive daytime somnolence. These patients have pathological hypersomnia, but are without the REM abnormalities of cataplexy, hypnagogic hallucinations, and sleep paralysis of narcolepsy. The NPSG shows no clinically significant sleep disturbance and other medical-psychiatric evaluations are unremarkable.

Excessive daytime sleepiness is a common clinical problem. Once sleep loss is eliminated as a cause of the problem, remaining patients with excessive daytime sleepiness may have a number of identifiable and treatable disorders which can be evaluated.

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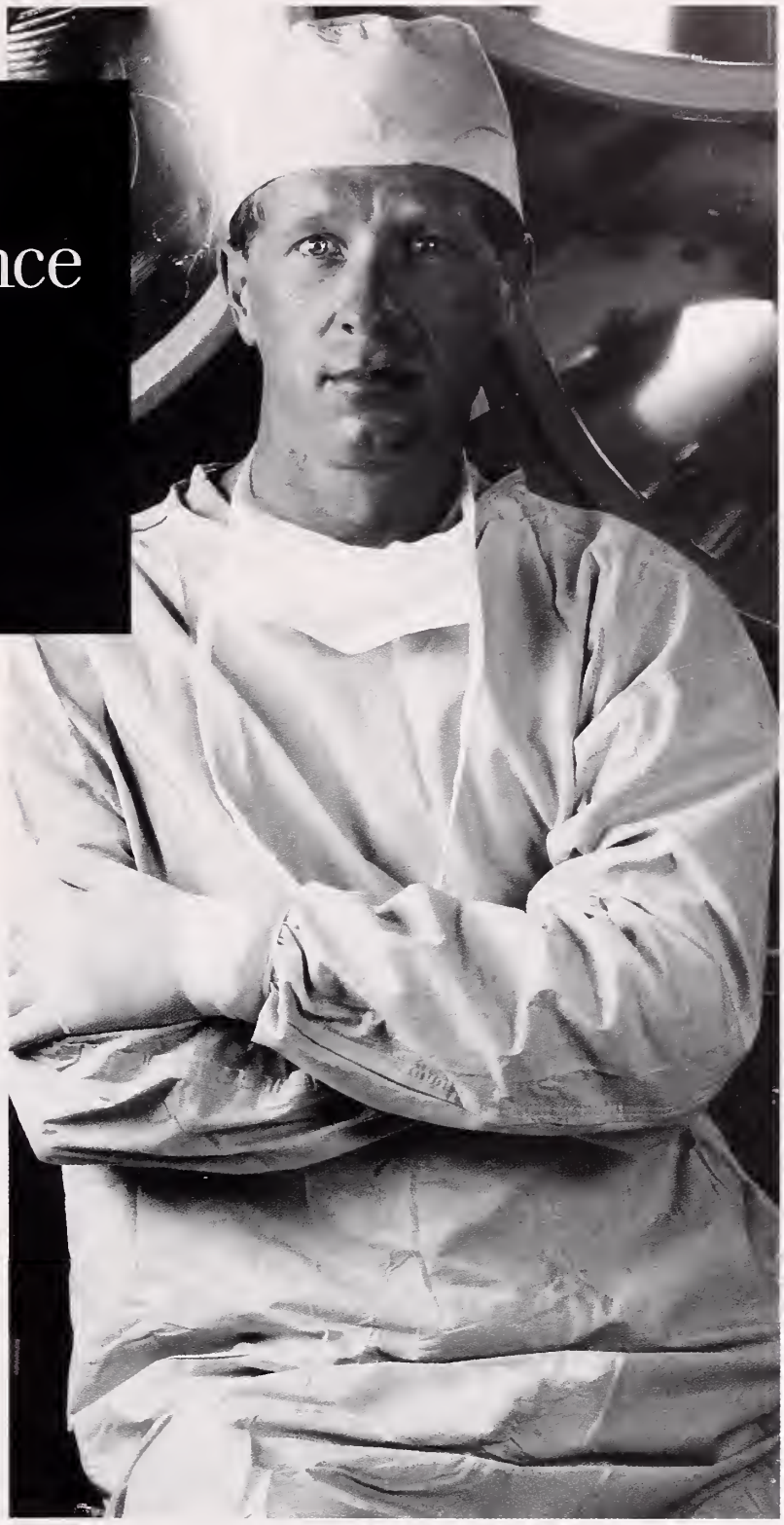

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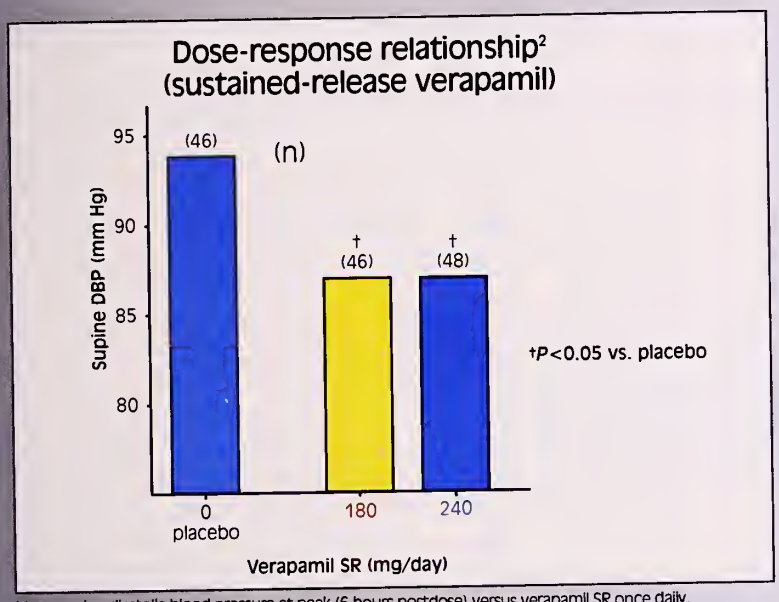

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SUSTAINED-RELEASE CAPLETS

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

References:

1. 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.
2. Data on file, G.D. Searle & Co.

A90CA4250T

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Medical & Scientific Information Department
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Skokie, IL 60077

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Box 5110, Chicago, IL 60680

Summertime

> ***'In medicine, it is a time of intensity as fresh new troops rise to the challenge of helping others. It is a time worthy of a moment's pause . . . to breathe in deeply all the images of Summertime, new beginnings, and shared ideals common to us all as physicians in training.'***

Over the last 10 years these pages have increasingly been filled with reflections of the changing face of medicine, reflections often of despair. These pages have reflected the concerns we've all shared regarding government and third party intervention in our decision making ability, loss of our autonomy, and changes in our professional demeanor made by the ever proliferating forces of advertising and self promotion.

Since these issues bombard us daily either in our attempts to conduct our professional lives or simply in our attempts to enjoy the radio on the way to work, it is understandable that much of our thinking on these pages has reflected these concerns.

But now it is Summertime, a time traditionally associated with the changing of the guard in medicine. Medical students have just had their first month as "real docs" on the wards. Comfortably, senior residents have left the academic world for their first months in private practice or with teaching appointments.

It is time to put aside the day-to-day fears and remember the reasons we all entered medicine originally. It is a time for wishing our new associates the best of luck in the beginning of their practices. It is a time for sharing the excitement and enthusiasm of the new residents' first days on the wards.

The young men and women entering and exiting medical training are beginning some of the most exciting professional times of their lives. Hopefully, they are in fields they have chosen because of their consuming interest in that area of medicine. With a freshness so characteristic of those days they are striving to give 110% to their education and their patients. It is a time for learning how to help their patients not only with the appropriate medical response but also the appropriate personal touch. It is a time for the melding of the art and science of medicine.

Summertime is a time for us to all welcome in the new and the enthusiastic among our ranks. Those of us who are also lucky enough to teach know we will learn equally as much from these enthusiastic inquiring minds and rejuvenate ourselves in the process. Gone are the days of "Summertime, when the livin' is easy, fish are jumpin', and the cotton is high." In medicine, it is a time of intensity as fresh new troops rise to the challenge of helping others. It is a time worthy of a moment's pause . . . to breathe in deeply all the images of Summertime, new beginnings, and shared ideals common to us all as physicians in training.

Martha Keeney Heyburn, MD

QUALITY CONTROL.

Four generations ago, in 1847, the AMA was founded "to promote the art and science of medicine and the betterment of the public health" by advancing the *quality* of medical care. And although this youngster doesn't know it, her future is brighter and her life expectancy is longer partly because of our dedicated efforts.

The factors influencing the quality of medical care today are more complex than they were in 1847. There are questions of evolving technologies, new delivery systems, policy debates, cost containment and more—each needing to be weighed to determine what constitutes the best quality care for individual patients.

But at the AMA, we still believe only physicians can provide the answers. That's why we continue to lead the medical community and design programs to inform, educate and monitor *ourselves*. And that's why we've recently established the AMA Office of Quality Assurance.

But our quality assurance efforts extend even further still. For example, to help physicians evaluate drugs, devices, and procedures, there's DATTA—the Diagnostic and Therapeutic Technology Assessment program.

These are two of the many activities at the AMA to improve quality health care. Because at the AMA, we're interested not only in the quality of medicine, but the quality of life.

Our members make a difference.
If you're already a member, we need your continued support. If you're not, JOIN TODAY.
Call 1-800-AMA-1452

AMA
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In most cases, medical association dues may be deductible as professional or business expenses.
Dues and other contributions to the AMA are not deductible as charitable contributions for Federal income tax purposes.

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Beef ... has a lot to offer a healthy, balanced diet. As a food that is nutrient dense, beef can meet many of the dietary guidelines that are recommended for healthy living. The booklets below are designed for your use in educating your patients about healthy diets. Just fill out and return the form below to receive a sample of each booklet that interests you. Included with the samples will be an order form if you would like to use the free booklets with your patients.

A Food Guide For The First Five Years

Designed for parents, this concise booklet includes feeding and meal preparation tips, suggestions for nutritious snacks and an explanation of nutrient density and energy balance. Helps parents give their child the most important gift of all, the gift of good health.

A Good Start

This nutrition guide for expectant mothers relates food needs during pregnancy to the growth and development of a healthy, full-term baby. The booklet includes information on weight gain during pregnancy, meal planning, snack suggestions and nutrition for the mother and baby.

50 Plus - A Growing Force

This no-nonsense pamphlet delivers the facts about beef's value in the diet of people over the age of 50. Nutritional information and shopping tips are combined with modern recipes and nutritional analysis to deliver a powerful message to this growing segment of the population.

Weekend Athlete

Tips on diet and exercise, including quotes from well-known athletes. Recipes with nutrient data are provided, along with a guide for selecting the leanest cuts of beef at the market.

Real Food Lover's Guide to Beef

Beef lovers will love this light-hearted guide to the joys of beef. Includes an overview of beef's nutritional benefits, contemporary beef recipes, and nutritional profiles.

Please send a sample of:

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_____A Good Start
_____Real Food Lover's Guide to Beef
_____The Weekend Athlete
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New from Kramer

"Charcoal Plus"

to stop gas in both the upper and lower tracts!

When your patients suffer from pain, bloating or diarrhea caused by excessive gas in the gastrointestinal tract, you often have a problem prescribing the proper medication. That's because you often don't know whether the distress is in the upper or lower tract.

If the problem is in the stomach, the cause is usually swallowed air. Simethicone has been proven effective in relieving this distress because Simethicone breaks up gas bubbles and expells them.

But if the problem is in the intestines, Simethicone is usually ***not*** effective. In the lower tract, bacterial degradation of undigested food creates the gas. There, activated charcoal (see article on right) is more effective in alleviating the distress.

Until now, no product combined ***both*** ingredients for relief in BOTH the upper and lower intestinal tracts.

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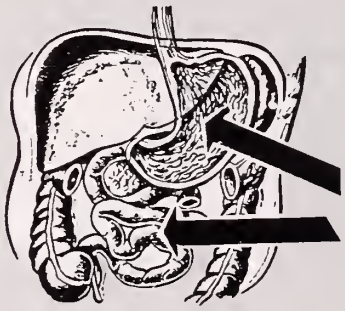
Signature_____

CHARCOAL PLUS combines the best of both. It has an activated charcoal core, an intermediate enteric coating and an outer coating with Simethicone as the active ingredient.*

When ***CHARCOAL PLUS*** is taken by your patient, the Simethicone acts first in the stomach. Then, after the 90 minutes required to dissolve the intermediate coating, ***CHARCOAL PLUS*** has reached the lower tract where the activated charcoal is exposed and ready to work.

CHARCOAL PLUS is the one product that takes the guesswork out of prescribing the best relief for intestinal gas and diarrhea. Simethicone alleviates upper gastrointestinal distress. Activated charcoal is an effective anti-gas medication in the lower tract. ***CHARCOAL PLUS*** has them both!



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Help Us!
"Improve the Image of Medicine"

Some of you have recently received a letter from the AKMA Health Career Fund Committee. The letter essentially is a request for your financial support of this Fund.

The fund-raising endeavor is in response to a motion passed at the 1990 AKMA House of Delegates endorsing the mission statement of the Kentucky Coalition on the Availability of Nurses. It is to be noted that this endorsement was made at the request of the Kentucky Medical Association.

Briefly stated, the purpose of the Health Career Fund of the AKMA is to offer educational scholarships to a small group of persons seeking a career in one of the medically associated disciplines such as nursing and the allied health field. Each year, the number of viable applicants for these scholarships increases while the available monies remain more or less stationary. To be more specific, there were 46 applicants this year, while we could only help seven.

Members of the Health Career Fund Committee are seeking pledges to total at least $20,000 so that a principal of at least $50,000 can be realized. The money given each year for scholarships is the interest on $30,000, plus $1 from each Auxiliary member.

Generous support of this program by the physicians of this state will certainly "Improve the Image of Medicine," the pledge of this year's medical auxiliary.

If you were not on the list of persons who received a personal request, accept our apology and regard this essay as a personal invitation to help this cause.

Mail donations for the Health Career Scholarship Fund to:

Jean Wayne
c/o Auxiliary to the Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, KY 40205

Betty Schrodt
AKMA President

FALL BOARD MEETING

September 24-26, 1990
Hyatt Regency Hotel
Louisville, Kentucky

AKMA Fall Board schedule will be published in the September 1990 issue of the KMA *Journal*.

Doctors Bailen, Schmied & Benson, P.S.C.

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Make Your Reservations Now

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 24-27. The Hyatt Regency Louisville will be the Headquarters Hotel (Phone (502) 587-3434). In making your reservations, remember the first House of Delegates meeting will be Monday, September 24. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate.

A NEW DECADE

• 1 9 9 0 •

Pride in Medicine

Kentucky Medical Association

Annual Meeting

[illegible]

Hyatt [illegible] Convention Center

Louisville, [illegible]

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Official Call
KMA Annual Meeting

To the officers and members of the component and county medical societies of the KMA.

Meeting Place

The Annual Meeting of KMA will convene on Tuesday, Wednesday, and Thursday, September 25, 26, & 27, at the Hyatt Regency Hotel and Commonwealth Convention Center, Louisville. The first General Session will be called to order at 8:30 am, Tuesday.

The House of Delegates

The first regular meeting of the House of Delegates will convene at 9:00 am, Monday, September 24, in the Regency Ballroom, located in the Hyatt Hotel. The second regular business meeting will begin at 7:00 pm, Wednesday, September 26, in the Regency Ballroom. **Please note that the Wednesday evening session of the House of Delegates is starting one hour later than in previous years.**

Registration

The Registration Desk, located outside the Regency Ballroom, 2nd Floor of the Hyatt Hotel, will be open for Delegates at 7:30 am, Monday, September 24, and at 6:00 pm, Wednesday, September 26. General registration will be held from 7:00 am until 5:00 pm, Tuesday; 7:30 am to 4:00 pm on Wednesday; and 7:30 am to 3:30 pm on Thursday, at the General Registration Desk located in the lobby of the Commonwealth Convention Center.

KMA Officers 1989-90

Nelson B. Rue, MD
KMA President
Bowling Green

Preston P. Nunnelley, MD
President-Elect
Lexington

On September 26, Nelson B. Rue, MD, will pass the leadership of the Kentucky Medical Association to Preston P. Nunnelley, MD, of Lexington.

Dr Rue, a native of Franklin, Tennessee, received his MD degree from the University of Louisville School of Medicine in 1956 and interned at St. Elizabeth Hospital in Louisville. He served in the U.S. Air Force and passed the American Board of Surgery while in the service. He is currently a practicing general surgeon in Bowling Green.

Active in organized medicine for many years, Dr Rue is a member of the Warren County Medical Society, AMA, the American College of Surgeons, and is a Diplomate of the American Board of Surgery.

In addition to his past year's service as President, Dr Rue has served KMA as 6th District Trustee from 1981-1987; two terms as Chairman of the Board of Trustees from 1984-1987; Vice-President in 1987-88; and served on the original ad hoc committee that implemented the Kentucky Physicians Care Program. He is a charter member of the Kentucky Health Care Access Foundation.

Dr Rue leaves behind him a very successful year as President of KMA.

Preston P. Nunnelley, MD, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, September 26.

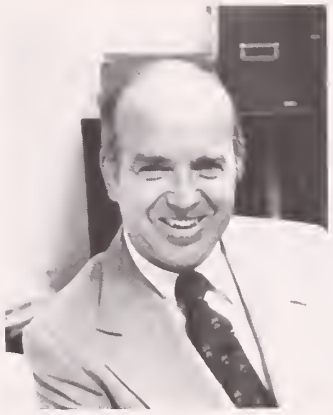
Dr Nunnelley, a native of Mt. Vernon, Kentucky, received a Bachelor of Science degree from Eastern Kentucky University, Richmond, in 1964, and an MD degree from the University of Kentucky College of Medicine in 1970. He completed a residency in OB-GYN at the University of Kentucky Albert B. Chandler Medical School in 1974 and has been in a partnership practice since that time. Dr Nunnelley is an Associate Clinical Professor in the OB-GYN Department of Family Medicine and the Department of Family Practice at the University of Kentucky College of Medicine.

A Fellow of the American College of Obstetrics and Gynecology, Dr Nunnelley is also a member of the AMA, American Fertility Society, and a past President of the Kentucky Obstetrical and Gynecological Society and the Fayette County Medical Society.

Dr Nunnelley served KMA as 10th District Trustee for five years and has served as Vice Chairman of the Board of Trustees. He also served on the Legislative Committee from 1982 to 1986 and the Nominating Committee in 1983. He currently is a member of the Kentucky Physician's Care Operating Committee; Committee on State Legislative Activities; Executive Committee; Scientific Program Committee; Membership Committee; and Ad Hoc Committee on Professional Liability Insurance.

Vice President
John D. Noonan, MD
Poducoh

Dr Noonan, a neurosurgeon, is in private practice in Paducah with affiliations at Western Baptist and Lourdes Hospitals. He received his MD from the University of Louisville School of Medicine in 1963. Dr Noonan is a member of the Congress of Neurological Surgeons; AMA; past president of the Kentucky State Neurosurgical Society; and past president of the McCracken County Medical Society. His service to KMA includes Delegate 1980-1982; Alternate Trustee 1981-1983; Trustee 1984-1989; and currently as a member of the Claims and Utilization Review Committee and Ad Hoc Committee on Professional Liability Insurance. Dr Noonan is a past vice-chairman of the KEMPAC Board and a past board member for the 1st Congressional District.



Secretary- Treasurer
S. Randolph Scheen, MD
Louisville

Dr Scheen was KMA Secretary for eight years before his election as Secretary-Treasurer in 1975. A dermatologist, he is a graduate of the University of Louisville and University of Minnesota medical schools. Dr Scheen serves the Association as Chairman of the Awards Committee and as a member of the Budget Committee, Judicial Council, and the Ad Hoc Committee on Professional Liability Insurance. He is a member of the American Academy of Dermatology and the Alumni Foundation of the Mayo Clinic, and is a regular participant on local television and radio programs, answering questions from the public on dermatology.

Speaker of the House
Danny M. Clark, MD
Somerset

Danny M. Clark, MD, is an obstetrician-gynecologist from Somerset and a graduate of the University of Cincinnati College of Medicine. Dr Clark has served KMA as Delegate from 1974-1980; 12th District Alternate Trustee from 1977-1980; and 12th District Trustee from 1980-86. He serves as Chairman of the Committee on Maternal and Child Health and is a member of the Committee on Constitution and Bylaws and The Ad Hoc Committee on Indigent Care. Dr Clark is a Fellow in the American College of Obstetricians and Gynecologists.

Vice Speaker of the House
C. Kenneth Peters, MD
Louisville

Dr Peters, a family practitioner, has served as KEMPAC chairman, on the KMA Legislative Committee 13 years, KMA Delegate 20 years, and has been a member of KMA since his first year of practice in 1963. He is currently president of the Jefferson County Medical Society, a Charter Fellow of the American Academy of Family Practitioners, and a member of the Jefferson County Academy of Family Practitioners. Dr Peters is a 1960 graduate of the University of Louisville School of Medicine.

KMA Delegates to AMA

Donald C. Barton, MD
Corbin

Dr Barton, a family practitioner, was elected AMA Delegate in 1984. A past Chairman of the KMA Board of Trustees and past President of the Association, Dr Barton served as KMA Delegate from 1977-79 and AMA Alternate Delegate in 1983. He is past President of the Whitley County Medical Society; past chairman of the KEMPAC Board; and was 15th District KMA Trustee from 1978-84. Dr Barton, a 1960 graduate of the University of Louisville School of Medicine, serves on numerous KMA committees.

Wally O. Montgomery, MD
Paducah

Dr Montgomery, a general surgeon, was elected an AMA Delegate in 1988. He has served KMA as President, Alternate AMA Delegate, Board Chairman of KEMPAC, and on numerous committees. He is the current Chairman of the Committee on State Legislative Activities. A 1962 graduate of the University of Louisville School of Medicine, Dr Montgomery is a Fellow of the American College of Surgeons, a Diplomate of the American Board of Surgery, and a member of the McCracken County Medical Society. He is on the staff of Lourdes and Western Baptist Hospitals where he has served as president of the medical staffs.

Kenneth P. Crawford, MD
Louisville

Dr Crawford was elected as AMA Alternate Delegate in 1977 and served consecutive terms until his election as a Delegate in 1987. He has served KMA on numerous committees and is currently a member of the Rules Committee of the House of Delegates and the Committee on Constitution and Bylaws. Dr Crawford, a pediatrician, earned his medical degree in 1946 from the University of Louisville School of Medicine and is Medical Director of the Commission for Handicapped Children. He is a member of AMA, a Fellow in the American Academy of Pediatrics, and a diplomate of the American Board of Pediatrics.

Harold L. Bushey, MD
Barbaurville

Dr Bushey was elected an AMA Delegate in 1989, having previously served as a KMA Delegate for 6 years; Alternate Trustee 1968-1972; 15th District Trustee 1972-1978; and Board Chairman of KEMPAC. He has served on numerous KMA committees and is currently Chairman, Technical Advisory Committee on Physician Services (Title XIX). A 1954 graduate of Rochester Medical School, Rochester, NY, Dr Bushey is an internist. He is a member of the Southern Medical Association and a past secretary of the Knox County Medical Society.

Journal Editors

A. Evan Overstreet, MD, Editor
Louisville

Dr Overstreet served on the Editorial Board for more than six years before becoming Editor of *The Journal* in September 1977. An internist, Dr Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.

Paul C. Grider, Jr, MD
Louisville

Dr Grider has served as Scientific Editor of *The Journal* since 1975. An internist, Dr Grider is a past president of the Louisville Society of Internists and a former President of the medical staff at Methodist Evangelical Hospital. He is a 1958 graduate of the University of Louisville School of Medicine.

Stephen Z. Smith, MD
Louisville

Dr Smith has served as Assistant Scientific Editor for *The Journal* since 1977. He also serves as book review author. A dermatologist, Dr Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of the KMA Claims and Utilization Review Committee, the American Academy of Dermatology, and the American Medical Association.

Milton F. Miller, MD
Louisville

Dr Miller is Associate Clinical Professor of Medicine at the University of Louisville School of Medicine. An internist, Dr Miller has served as Assistant Editor of *The Journal* since 1976, has been on the Membership Committee of the Jefferson County Medical Society, and is a former President of the medical staff at Methodist Evangelical Hospital. He is a 1954 graduate of the University of Louisville.

McHenry S. Brewer, MD
Louisville

Dr Brewer is serving his seventh year as Assistant Editor of the *Journal of the Kentucky Medical Association.* A surgeon, Dr Brewer attended the University of Louisville School of Medicine and was President of the Jefferson County Medical Society in 1972-73. He is a fellow of the American College of Surgeons and a member of the Southern Surgical Association.

Martha Keeney Heyburn, MD
Louisville

Dr Heyburn joined *The Journal* in 1986 as an Assistant Editor. An ophthalmologist, Dr Heyburn is a 1980 graduate of the University of Louisville School of Medicine. She has served the Jefferson County Medical Society as an Alternate Delegate to KMA, is a member of the American Academy of Ophthalmology, the American Medical Association, and has been a member of KMA since 1981.

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Fifteenth District

David C. Liebschutz, MD
Twelfth District

New Trustees

Robert P. Meriwether, MD
Paducah

Dr Meriwether is serving as Trustee from the 1st District. He is also a member of the KMA Physician-Attorney Liaison Committee. A neurosurgeon, Dr Meriwether has served as Chief of Staff at Lourdes Hospital and Chief of Surgery at Western Baptist Hospital in Paducah. He is an Assistant Professor of Neurological Surgery at the University of Kentucky College of Medicine. A 1973 graduate of the Tulane University Medical Center in New Orleans, Dr Meriwether is a member of the Congress of Neurological Surgeons; Board of Southern Neurosurgical Society; Diplomate of the American Association of Neurological Surgeons; and a Fellow of the American College of Surgeons.

William L. Miller, MD
Greenville

Dr Miller is serving as Trustee from the 3rd District. His past service to KMA includes several terms as an Alternate Delegate and Delegate for Muhlenberg County. He is the current Specialty Group and Geographic Representative for Pathologists on the Ad Hoc Committee on Professional Liability Insurance. Dr Miller is a pathologist and is a member of the College of American Pathologists; American Society of Hematology; International Academy of Pathologists; Kentucky Society of Pathologists; and a Fellow of the American Society of Clinical Pathologists. A native of Louisville, Dr Miller graduated cum laude from the University of Louisville School of Medicine in 1959.

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Allen
Earl P. Oliver, MD, Scottsville

Anderson
William P. McElwain, MD, Lawrenceburg

Ballard

Barren
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Carlisle

Carroll
Benjamin Kutnicki, MD, Warsaw

Carter

Casey
Lewis E. Wesley, MD, Liberty

Clark

Clay
Ira F. Wheeler, MD, Manchester

Clinton
Michael Lee Cummings, MD, Albany

Crittenden
Scott R. Graham, MD, Marion

Cumberland
Samuel Lee Rice, MD, Burkesville

Daviess
Bill J. Bryant, MD, Owensboro
John D. Jefferies, MD, Owensboro
Christopher R. McCoy, MD, Owensboro
R. Wathen Medley, Jr, MD, Owensboro
W. Neil Padgett, MD, Owensboro
Robert L. Reid, MD, Owensboro

Edmondson
Omkar N. Bhatt, MD, Brownsville

Elliott

Estill

Fayette
John R. Allen, MD, Lexington
Peter P. Bosomworth, MD, Lexington
Ralph D. Caldroney, MD, Lexington
Dorothy H. Clark, MD, Lexington
John W. Collins, MD, Lexington
John D. Cronin, MD, Lexington
Elvis S. Donaldson, Jr, MD, Lexington
Harold T. Faulconer, MD, Lexington
John M. Fox, MD, Lexington
William F. Gee, MD, Lexington
Bill H. Harris, MD, Lexington
Dennis B. Kelly, MD, Lexington
Daniel E. Kenady, Sr, MD, Lexington
John L. Kiesel, MD, Lexington
William D. Medina, MD, Lexington
Andrew M. Moore, II, MD, Lexington
Franklin B. Moosnick, MD, Lexington
Barbara A. Phillips, MD, Lexington
John W. Poundstone, MD, Lexington
Andrew R. Pulito, MD, Lexington
Barry N. Purdom, MD, Lexington
David B. Stevens, MD, Lexington
John D. Stewart, MD, Lexington
Gary R. Wallace, MD, Lexington

Fleming
Glenn R. Womack, MD, Flemingsburg

Floyd
Nicholas R. Jurich, MD, Prestonsburg

Franklin
Joseph J. Dobner, MD, Frankfort
Willis P. McKee, Jr, MD, Frankfort

Fulton

Gallatin

Garrard
Paul J. Sides, MD, Lancaster

Grant

Graves
Robert D. Fields, MD, Mayfield
Charles D. LeNeave, MD, Mayfield

Grayson

Green

Greenup
Manuel S. Garcia, MD, Ashland
John O. Jones, MD, Flatwoods

Hancock

Hardin-Larue
Arvil G. Catlett, MD, Hodgenville
Nga T. Nguyen Collard, MD, Elizabethtown
Marion A. Douglass, Jr, MD, Magnolia
James T. Engle, Jr, MD, Elizabethtown
William C. Nash, MD, Elizabethtown

Harlan
Rachel R. Eubank, MD, Harlan
James K. Hurlocker, MD, Harlan

Harrison
Donald R. Stephens, MD, Cynthiana

Hart
Keene M. Hill, MD, Horse Cave

Henderson
Frank K. Sewell, Jr, MD, Henderson
Rogelio A. Silva, MD, Henderson

Hickman
Bruce C. Smith, MD, Clinton

Hopkins
Wallace R. Alexander, MD, Madisonville
James M. Bowles, MD, Madisonville
Charles R. Dodds, MD, Earlington
William H. Klompus, MD, Madisonville

Jackson

Jefferson
Arnold M. Belker, MD, Louisville
Charles J. Bisig, Jr, MD, Louisville
David H. Bizot, MD, Louisville
Harold W. Blevins, MD, Louisville
Mark Bronner, MD, Louisville
Philip T. Browne, MD, Louisville
Wm. C. Buschemeyer, Jr, MD, Louisville
Peter C. Campbell, MD, Louisville
Alvin M. Churney, MD, Louisville
Stuart P. Cohen, MD, Louisville
J. William Comer, MD, Louisville
Sue A. Cutliff, MD, Louisville
Robert Craig DeWeese, MD, Louisville
John H. Doyle, MD, Louisville
Samuel G. Eubanks, Jr, MD, Louisville
Mary E. Fallat, MD, Louisville
John M. Farmer, MD, Louisville
Marjorie R. Fitzgerald, MD, Louisville
Kamla Gauri, MD, Louisville
Darius Ghazi, MD, Louisville
Cecil L. Grumbles, MD, Louisville
Harold D. Haller, MD, Louisville
B. Thomas Harter, Jr, MD, Louisville
Louis S. Heuser, MD, Louisville
Albert B. Hoskins, III, MD, Louisville
Walter I. Hume, MD, Louisville
John M. Karibo, MD, Louisville
Lowell D. Katz, MD, Louisville
Arthur H. Keeney, MD, Louisville
Virginia T. Keeney, MD, Louisville
Donald R. Kmetz, MD, Louisville
Forrest S. Kuhn, Jr, MD, Louisville
Joseph E. Kutz, MD, Louisville
John A. Lloyd, MD, Louisville
Charles F. Mahl, MD, Louisville
Gorden T. McMurry, MD, Louisville
Ralph C. Morris, MD, Louisville
Syed M. Nawab, MD, Louisville
Robert L. Nold, MD, Louisville
Charles R. Oberst, MD, Louisville
Lynn L. Ogden, MD, Louisville
Hobert L. Pence, MD, Louisville
Thomas P. Rankin, MD, Louisville
James E. Redmon, MD, Louisville
K. Thomas Reichard, MD, Louisville
George Randolph Schrodt, MD, Louisville
George R. Schrodt, Jr, MD, Louisville
Kerry L. Short, MD, Louisville
C. Steven Smith, MD, Louisville
Robert S. Tillett, MD, Louisville
Daniel W. Varga, MD, Louisville
William P. VonderHaar, MD, Louisville
Thomas R. Watson, MD, Louisville
Peter H. Wayne, III, MD, Louisville
Samuel D. Weakley, MD, Louisville
Barbara Weakley-Jones, MD, Louisville
A. Franklin White, Jr, MD, Louisville
Larry J. Wilson, MD, Louisville
C. Milton Young, III, MD, Louisville
Kenneth N. Zegart, MD, Louisville

Jessamine

Johnson

Knott

Knox
Rogelio A. Acosta, MD, Barbourville

Laurel
David W. Douglas, MD, London

Lawrence

Lee
James B. Noble, MD, Beattyville

Leslie

Letcher

Lewis

Lincoln

Livingston
Stephen Burkhart, MD, Salem

Logan
Lewis E. Martin, MD, Russellville

Madison
Clifford F. Kerby, MD, Berea

Magoffin

Marion
David B. George, MD, Lebanon

Marshall

Martin

Mason
Audrey Spencer, MD, Maysville

McCracken

McCreary

McLean

Meade
Raymond L. Mathis, DO, Brandenburg

Menifee

Mercer
Nick G. Dedman, MD, Harrodsburg

Metcalfe

Monroe
James E. Carter, MD, Tompkinsville

Montgomery

Morgan
George R. Bellamy, MD, West Liberty

Muhlenberg
James S. Brashear, MD, Central City

Nelson

Nicholas

Northern Kentucky
Gordon W. Air, MD, Crestview Hills
Charles F. Allnutt, MD, Covington
John Franklin Allnutt, MD, Villa Hills
John D. Ammon, MD, Florence
Harry W. Carter, MD, Covington
James H. Linne, MD, Park Hills
Carol S. Milburn, MD, Crestview Hills
Theodore H. Miller, MD, Covington
Mary Redden Borowski, MD, Covington
Michael L. Robinson, MD, Edgewood
B. Robert Schwartz, MD, Edgewood
Charles L. Stephens, MD, Fort Thomas
Frederick A. Stine, MD, Highland Heights
Steven M. Woodruff, MD, Florence

Ohio

Owen

Owsley

Pendleton
Robert L. McKenney, MD, Falmouth

Pennyrile
Emmanual J. Battah, MD, Hopkinsville
Hank Bell, Jr, MD, Elkton
Hany J. Dempsey, MD, Hopkinsville
Steve Hiland, MD, Eddyville
Nathaniel H. Talley, MD, Princeton
J. Nicholas Terhune, MD, Hopkinsville

Perry

Pike

Powell

Pulaski
Donald E. Brown, MD, Somerset
Gregory J. Sherry, MD, Somerset
Joseph G. Weigel, MD, Somerset

Robertson

Rockcastle

Rowan
Lauren B. Zoschnick, MD, Morehead

Russell
Rick S. Miles, MD, Russell Springs

Scott
James C. Cantrill, MD, Georgetown

Shelby-Henry-Oldham
Harold F. Funke, MD, Crestwood
Ronald Waldridge, MD, Shelbyville
David W. Wallace, MD, Shelbyville

Simpson
Michael Pulliam, MD, Franklin

Spencer
William K. Skaggs, MD, Taylorsville

Taylor
Eugene H. Shively, MD, Campbellsville

Trimble
Roderick H. MacGregor, MD, Bedford

Union
Wallas N. Bell, MD, Morganfield

Warren
Craig Alvin Beard, MD, Bowling Green
Jane R. Bramham, MD, Bowling Green
John E. Downing, MD, Bowling Green
John D. Gover, MD, Bowling Green

Washington
Charles D. Howard, MD, Springfield

Wayne
James K. Phillips, Jr, MD, Monticello

Webster

Whitley
Frank H. Catron, MD, Corbin
Jagdish S, Patil, MD, Corbin
Carmel Wallace, Jr, MD, Corbin

Wolfe
Paul F. Maddox, MD, Campton

Woodford

KMA Hospital Medical Staff Section
David R. Watkins, MD, Louisville

KMA Resident Physicians Section
Laura Ann Spalding, MD, Louisville

KMA Student Section
Kela J. Lyons, Louisville
Paul McLaughlin, Lexington

Elections

Nominating Committee to Meet Monday, September 24

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates, Monday, September 24, in the Regency Ballroom of the Hyatt Regency Hotel. Any KMA member may confer with the Committee during this meeting.

The report of the Nominating Committee will be posted in the general assembly hall at the conclusion of the first general session, Tuesday morning, September 25.

Nominations may be made from the floor during the second meeting of the House of Delegates, Wednesday evening, September 26, in the Regency Ballroom. The House will vote on the nominees at this meeting.

Members of the Committee are: Charles F. Allnutt, MD, Edgewood, Chairman; Bill H. Harris, MD, Lexington; Willis P. McKee, Jr, MD, Shelbyville; Susan H. Prasher, MD, Ashland; and George R. Schrodt, Jr, MD, Louisville.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office, Attention, Nominating Committee.

House to Elect New Officers During Annual Meeting

KMA officers for the 1990-91 Association year will be elected by the House of Delegates at the close of its final meeting, Wednesday evening, September 26. Officers to be elected from the state-at-large are:

Office	Term
President-Elect	1 Year
Vice President	1 Year
Secretary-Treasurer	3 Years
*S. Randolph Scheen, MD Louisville	
Delegates to the AMA	2 Years
*Kenneth P. Crawford, MD Louisville	
*Wally O. Montgomey, MD Paducah	
Alternate Delegates to the AMA	2 Years
*Robert R. Goodin, MD Louisville	
*Ardis D. Hoven, MD Lexington	

*Incumbent

Election of Trustees and Alternate Trustees

The House of Delegates will elect five District Trustees and five Alternate Trustees at its second regular meeting, Wednesday, September 26. Nominations will be made by the Delegates from the electing Districts at a meeting following the first meeting of the House on Monday, September 24.

The Nominating Committee will report at the close of the first scientific session on Tuesday, September 25. Further nominations may be made from the floor at the final meeting of the House on Wednesday evening, September 26. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for three-year terms are: **5th District** (incumbent, Larry P. Griffin, MD, Louisville); **6th District** (incumbent, Jerry W. Martin, MD, Bowling Green); **8th District** (incumbent, William B. Monnig, MD, Edgewood); **11th District** (incumbent, William H. Mitchell, MD, Richmond); and **15th District** (incumbent, Emanuel H. Rader, MD, Pineville).

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: Gorden T. McMurry, MD, Louisville, 5th District; Jerry L. Gibbs, MD, Glasgow, 6th District; Mark F. Pelstring, MD, Covington, 8th District; John M. Johnstone, MD, Richmond, 11th District, and Paul R. Smith, MD, London, 15th District.

Trustees in the 5th, 6th, and 11th Districts are eligible for reelection, while the Trustees in the 8th and 15th Districts have served two full, consecutive terms and are not eligible for reelection.

Alternate Trustees in the 5th, 6th, 8th, 11th and 15th Districts are all eligible for reelection.

Reference Committee Activity

Speakers Danny M. Clark, MD, Somerset, and C. Kenneth Peters, MD, Louisville, will assign all officers' and committees' reports and Resolutions to one of six Reference Committees at the first meeting of the KMA House of Delegates at 9:00 am, Monday, September 24. A brief session for Reference Committee Chairmen will be held at 12:30 pm, Monday in the Derby Room, located in the Hyatt Hotel. Any KMA member wishing to testify on any Resolution or report is urged to be present for the Reference Committee meetings which will be held at 2:00 pm, Monday, September 24, in the meeting rooms in the Hyatt Hotel. These open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the Committees will go into executive sessions to study the reports, review the testimony, and write their reports to the House.

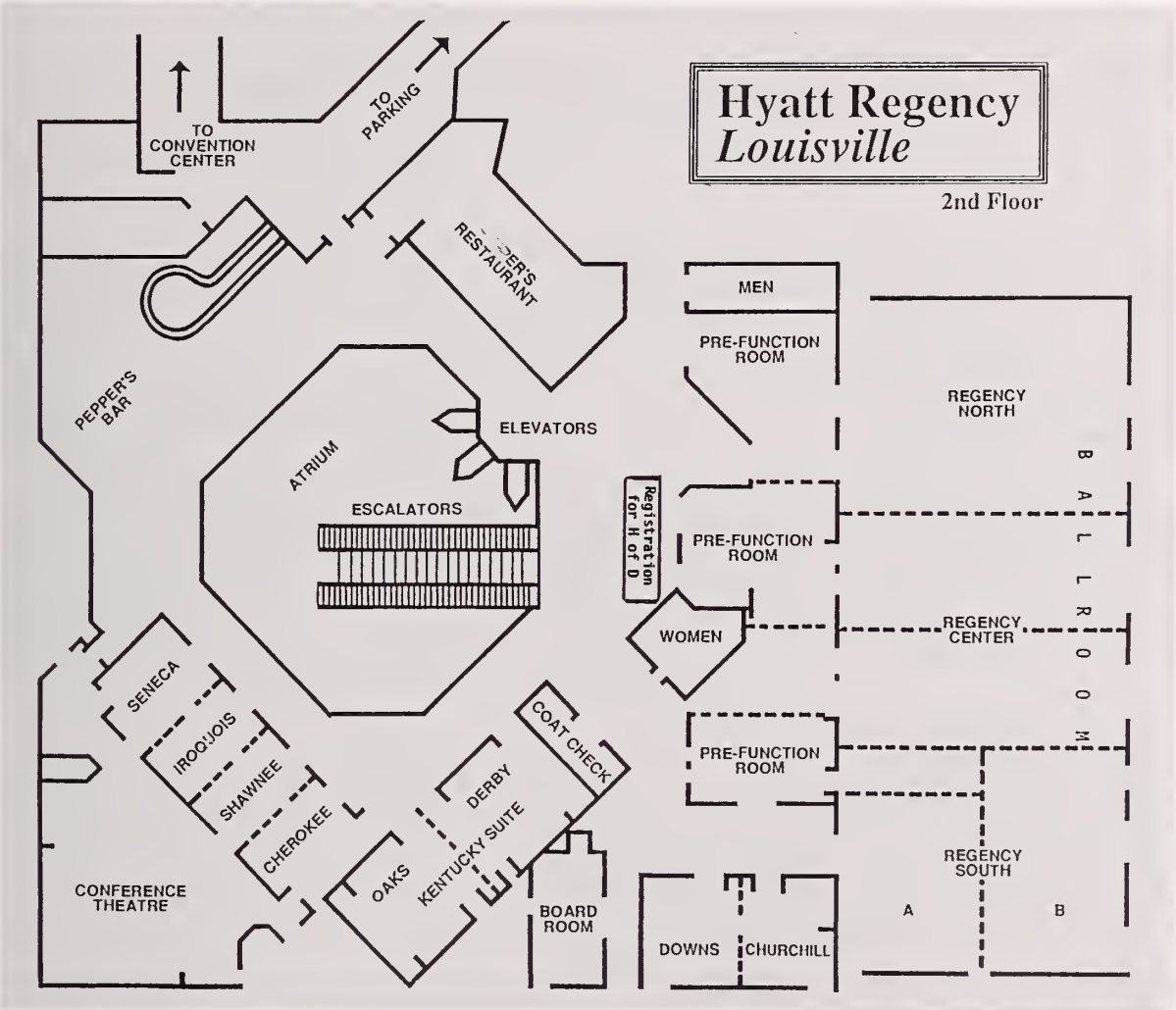
The Committees' recommendations will be presented at the final meeting of the House, Wednesday evening, September 26, in the Regency Ballroom, Hyatt Hotel.

Appointments to Reference Committees and Credentials Committee and Tellers are now being finalized by the Speakers.

If your society has not yet submitted the name of your Delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of the Reference Committees and be listed as official county representatives.

A complete listing of members who will be serving on the six Reference Committees and the location of the Reference Committee meetings will be published in the September issue of the KMA *Journal*.

Anyone desiring names of Reference Committee members before the September issue is published should contact the Headquarters Office.



Capsule Schedule of 1990 Annual Meeting

CC = Commonwealth Convention Center
HH = Hyatt Regency Hotel (2nd Floor)

	Sunday, September 23	
9:00 AM	KMA Executive Committee Meeting	Derby Room-HH
12:30 PM	KMA Board of Trustees Meeting & Lunch	Regency South-HH
	Monday, September 24	
7:30 AM	Registration for House of Delegates	Outside Regency Ballroom-HH
7:30 AM	Continental Breakfast for House of Delegates hosted by JCMS	Regency Ballroom Foyer-HH
9:00 AM	First Meeting, KMA House of Delegates	Regency Ballroom-HH
10:00 AM	Auxiliary Committee Meetings	Regency South A-HH
12:30 PM	Luncheon, Reference Committee Chairmen	Derby Room-HH
2:00 PM	Reference Committee Meetings	Various Meeting Rooms-HH
6:00 PM	KEMPAC Reception & Dinner	Regency Ballroom-HH
	Tuesday, September 25	
7:00 AM	KEMPAC Board Breakfast Meeting	Regency South A-HH
7:00 AM	Maternal Mortality Committee Breakfast	Derby Room-HH
7:00 AM	Registration	Registration Area-CC
7:45 - 8:30 AM	Free Coffee & Danish	Exhibit Hall-CC
8:00 - 9:00 AM	Reference Committee Report Signing	Churchill Downs-HH
8:30 AM	Opening Ceremonies, First Scientific Session	General Sessions Area-CC
9:00 AM	Auxiliary Fall Board Meeting	Conference Theatre-HH
12:00 NOON	Luncheon Meeting, Executive Committee & Reference Committee Chairmen	Derby Room-HH
1:30 PM	Specialty Group Sessions . . . (Seven Specialty Groups will meet simultaneously at this time. Their programs begin on page 432)	Various meeting rooms-CC
	Wednesday, September 26	
7:15 AM	KMIC-sponsored Breakfast	Regency Ballroom-HH
7:30 AM	Registration	Registration Area-CC
7:45 - 8:30 AM	Free Coffee & Danish	Exhibit Hall-CC
8:40 AM	Second Scientific Session	General Sessions Area-CC
10:00 AM	Statewide CATO Society Meeting	Kentucky Suite-HH
11:50 AM	President's Installation/Awards Luncheon	Regency Ballroom-HH
2:15 PM	Specialty Group Sessions . . . (Seven Specialty Groups will meet simultaneously at this time. Their programs begin on page 437)	Various meeting rooms-CC
3:00 PM	KMA Board of Trustees Meeting & Dinner	Regency South-HH
7:00 PM	Second Meeting, KMA House of Delegates	Regency Ballroom-HH
	Thursday, September 27	
7:30 AM	Registration	Registration Area-CC
7:45 - 8:30 AM	Free Coffee & Danish	Exhibit Hall-CC
8:25 AM	Third Scientific Session	General Sessions Area
12:00 NOON	KMA Board of Trustees Luncheon Meeting	Regency South-HH
1:30 PM	Specialty Group Sessions . . . (Seven Specialty Groups will meet simultaneously at this time. Their programs begin on page 440)	Various meeting rooms-CC

A 30-minute intermission has been scheduled during each morning Scientific Session and each afternoon Specialty Group Session for visiting Exhibits.

Annual Meeting Special Features

A NEW DECADE

• 1 9 9 0 •

Pride in Medicine

KMA ANNUAL MEETING • SEPTEMBER 24-27 • HYATT REGENCY-COMMONWEALTH CONVENTION CENTER • LOUISVILLE, KENTUCKY

1990 Annual Meeting Honors Past President Joseph Ezra Wells, MD

The 1990 Annual Meeting of the Kentucky Medical Association will be officially titled "The Joseph Ezra Wells Meeting" in remembrance of the 1910 President of the Association. The tradition of honoring a past president of KMA and other distinguished physicians originated with the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Dr. Shirley that begins on page 429.

Scientific Sessions are scheduled for September 25, 26, & 27 at the Commonwealth convention Center in Louisville. The theme for the 1990 scientific session is "Pride in Medicine — A New Decade." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

Twenty-two Specialty Groups will hold meetings on the afternoons of September 25, 26 & 27. Beginning at 1:30 pm on Tuesday and Thursday and 2:15 pm on Wednesday, they will be held in the meeting rooms located on the lower level of the Commonwealth Convention Center. Individual programs of specialty societies are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet all three afternoons with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

Scientific and Technical Exhibits will display new medical products, services and techniques in the Exhibit Hall, located in the Commonwealth Convention Center during the 1990 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

The KMA House of Delegates will meet twice during the Annual Meeting. The first meeting of the House will be held at 9:00 am, Monday, September 24, in the Regency Ballroom located in the Hyatt Hotel. The final meeting will be held Wednesday, September 26, at 7:00 pm, also in the Regency Ballroom. **Please note that the Wednesday evening session of the House of Delegates is starting one hour later than in previous years.** Officers for the 1990-91 Associational year will be elected at the second meeting.

The President's Installation & Awards Luncheon will be held on Wednesday, September 26, in the Regency Ballroom located in the Hyatt Hotel. The luncheon will include the presentation of KMA awards and the installation of the 1990-91 President, Preston P. Nunnelley, MD, Lexington.

The 28th Annual KEMPAC Seminar-Banquet Is Fast Approaching! ! !

Make Plans To Attend

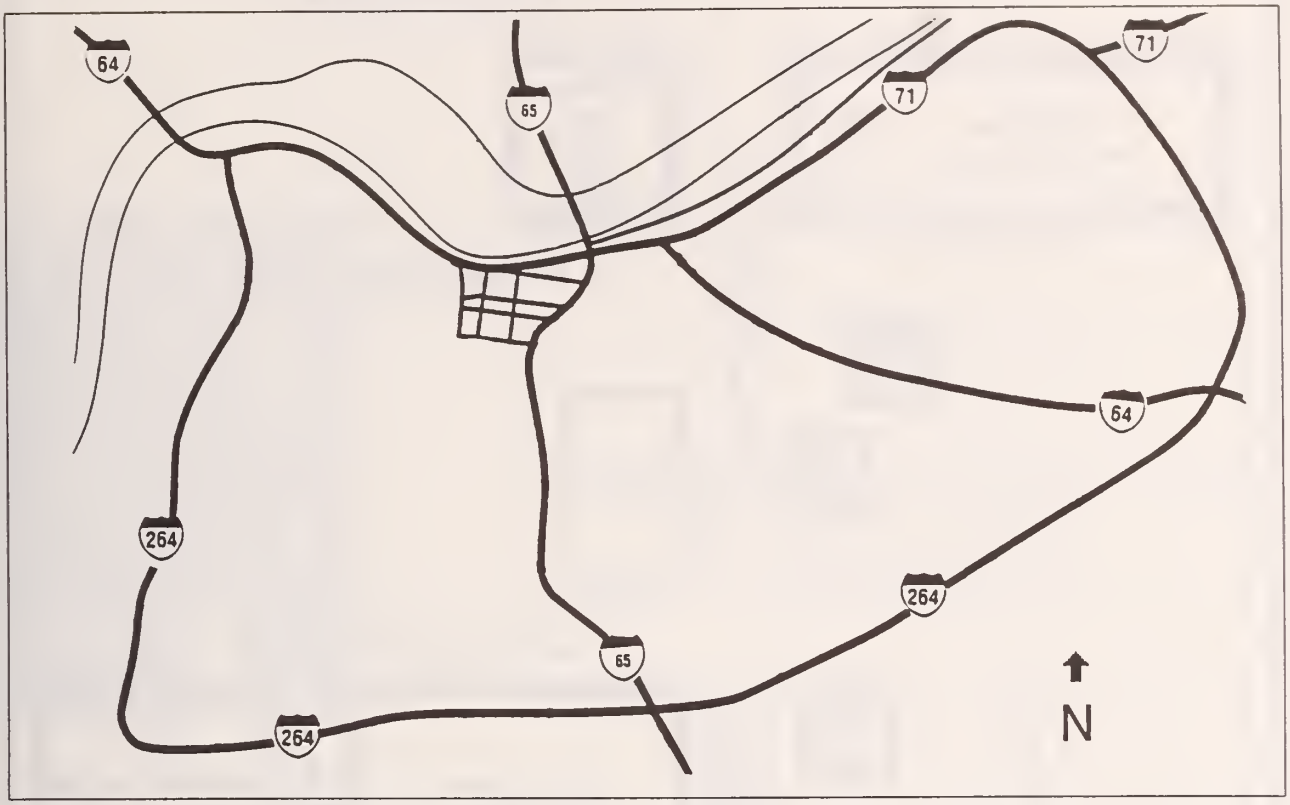
SENATOR MITCH McCONNELL
AND
DOCTOR HARVEY SLOANE

have been invited as our special guests
to address the seminar

Monday, September 24, 1990
6:00 PM EDT — Reception
7:00 PM Dinner with Program
to follow
Regency Ballroom North and 1/2 Center
Hyatt Regency Hotel
Louisville, KY

ADDITIONAL INFORMATION WILL BE COMING IN THE SEPTEMBER ISSUE

TO REACH HYATT REGENCY/ COMMONWEALTH CONVENTION CENTER

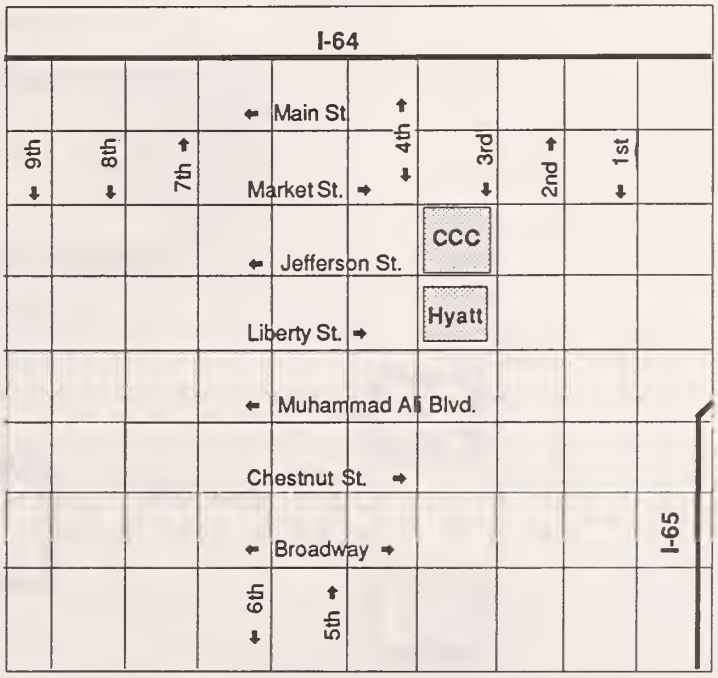


From I-64/1-71 Westbound:
Take 3rd St. exit, go south on 3rd, turn right on Jefferson.

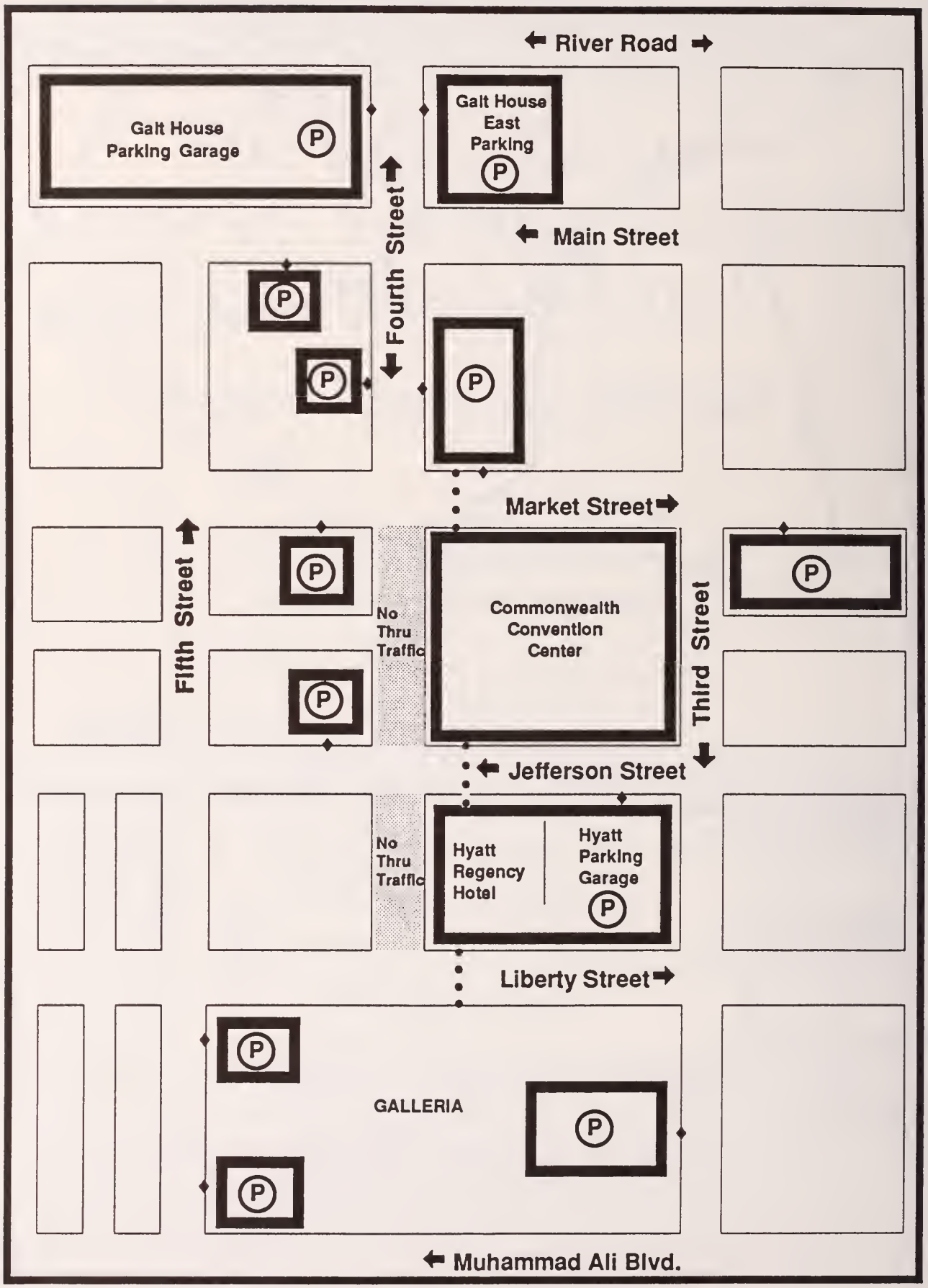
From I-64 Eastbound:
Take 9th St. exit, go south on 9th, turn left on Market.

From I-65 Northbound:
Take Muhammad Ali Blvd. exit, go west on Muhammad Ali, turn right at 2nd St., turn left at Jefferson.

MAP INSET OF DOWNTOWN LOUISVILLE



PARKING MAP



♦ denotes parking garage entrances

• • • denotes covered walkways from garages/Galleria

Dr Wells in 1910, when he was President of the Kentucky State Medical Association

Joseph Ezra Wells, MD 1860-1938

The gentleman whom we honor at this 140th Annual Meeting of the Kentucky Medical Association served the physicians, his patients, and the general public in numerous ways and always with his unselfish spirit. He assumed the Presidency of our society at the annual meeting in Lexington, on 21 October 1909.[1] He had been known throughout the state for his efforts in promoting public health measures. A long period of service on the Kentucky Board of Health was characterized by his assisting J. N. McCormack in writing and obtaining passage of new legislation concerning public health in county and state legislative bodies. He was well known, likewise, as a fervent and indefatigable organizer who had served several terms as KMA Councilor in the 8th Congressional District. He took his Councilor duties seriously, as he did all of his appointed tasks. He visited each county medical society in his district (12 in all). By addressing these medical societies on a variety of topics, including interesting case reports, he sparked regular county society meetings and increased their memberships and attendance, thereby making those societies very real functional components of the KMA.

Joe Wells, as he was known, was born 25 October 1860, in Mt. Olivet, Robertson County, Kentucky, the son of Riley Wells, MD, and Elizabeth Brown Wells.[2] He had one sister, Mrs Mary Wells Ridgely.

Wells received his preliminary education in the public schools of Robertson County and his baccalaureate degree from Transylvania College. His medical education was undertaken at the Ohio Medical College, Cincinnati, Ohio, from which he received his MD in 1881.[3] His preceptorship was conducted by his father, Riley Wells, MD, and his two uncles, Jasper Wells, MD, and Natt Wells, MD. He began his practice in Mt. Olivet immediately following the receipt of his MD but later (1896) moved to Cynthiana in Harrison County where he practiced until age and infirmity forced his retirement at age 77 on 1 July 1937. Upon moving to Cynthiana, Dr Wells formed a partnership with his classmate at medical school, N. W. Moore, MD, and they joined L. S. Givens, MD. The Givens, Wells, and Moore partnership continued for some years.

Dr Wells married Miss Elizabeth Ridgely Peekover on 16 May 1883. To them was born one daughter, Bird Wells (Mrs John H. Mayer).

During the Depression, Dr Wells was one of the committee of the Harrison County Medical Society who sought $1,000 from the Fiscal Court for the Health and Welfare League.[5]

Dr Wells served several times as President and also Secretary of the Harrison County Medical Society. Always interested in the welfare of his fellow man, Wells was a member of a committee to address all county medical societies in Kentucky early in 1909, with a plea for a Doctors' Home for the support and maintenance of disabled phy-

sicians. This project had been suggested by E. C. Anderson, MD, and the Christian County Medical Society in May 1908.[6] Efforts are traceable in the *Journal* for over a year, but the project apparently did not receive wide interest and support and was abandoned.

In 1909, Wells was chairman of the Committee on Legislation and Public Policy which, with the help of C. Z. Aud, MD, the KMA Delegate to the AMA, went on record seeking the establishment of a US Department of Health whose director would be a cabinet officer.[7] Their goal ultimately was achieved.

During the fall of 1913, there was an epidemic of diphtheria in Harrison County and the physicians there examined the school children every day for six weeks until the disease was controlled.[8] Wells' interest in public health is evident not only in his professional activities. His Presidential Address[9] is a very thorough review of what preventive medicine could and should accomplish. Although a ready and frequent speaker, he published very little except his Presidential Address.

During World War I, there was a nationwide epidemic of Spanish Influenza which had begun in Europe and entered the United States on our east coast. By September 1918, the first cases were observed in Louisville, next among soldier recruits at Camp Taylor, and by October, there was a statewide epidemic. Dr Wells was not in the Army but as a member of the Volunteer Medical Services during this "flu" epidemic,[10] he served in the 600-bed US Army Hospital at Nitro, West Virginia. The hospital had been built to serve the construction and ammunitions workers as well as civilian and military personnel in this new city of approximately 30,000 containing the largest explosives plant in the world at the time. During the fall and winter of 1918, there were 219 deaths from the "flu" at this hospital.[11, 12] How long Wells served at this hospital is not known.

Dr Wells was a member of the Cynthiana Christian Church and a member of the Masonic Lodge, Knights Templar, Knights of Pythias, The Elks and The Rotary Club.

In 1907, he had helped establish the Harrison Memorial Hospital in Cynthiana, KY, and had served on the staff and the board until his retirement.

Dr Wells died on 3 September 1938, just a little over a year following his retirement. His body was cremated and his ashes buried in the family plot at Battle Grove Cemetery on 7 September 1938.

Joseph Ezra Wells' greatest contributions to medicine were concerned with the promotion of public health and preventive medicine and the organization of a strong Kentucky State Medical Association.

Eugene H. Conner, MD
KMA Historian

References

1. House of Delegates. *KMJ* 7, 947, 1 Nov 1909.
2. *Cynthiana* [KY] *Democrat,* Cynthiana, KY, Thursday, 8 Sept 1938.
3. Deaths, *JAMA* 111, 213, 3 Dec 1938.
4. Moore NW, Tribute to JE Wells. *KMJ* 36, 446, Nov 1938.
5. Harrison County Medical Society. *KMJ* 25, 78, 1927.
6. Proceedings of KSMS. *KMJ* 7, 296-297, Apr 1909.
7. Proceedings of KSMS. *KMJ* 7, 945-946, 1 Nov 1909.
8. Harrison County Medical Society. *KMJ* 11, 861, 1 Oct 1913.
9. Wells JE. President's Address. Preventive Medicine. *KMJ* 8, 1946-1952, 15 Oct 1910.
10. WPA writer's interview with Dr Wells' daughter, Mrs Bird Wells Mayer, on 2 June 1939. Copy on file and on microfilm in Medical Archives at Kornhauser Health Sciences Library, UL, Louisville, KY.
11. Notes of an interview with Mr William D. Wintz of St. Alban's, WV. Thursday, 31 May 1990. Wintz, WD. *NITRO, the WWI Boom Town.*
12. Cohen S, Andre R: *Kanawha County Images, A Bicentennial History, 1788-1988,* Pictorial Histories Publishing Company, Charleston, WV 1987, pages 168, 445.

Kentucky Medical Association

Scientific Program

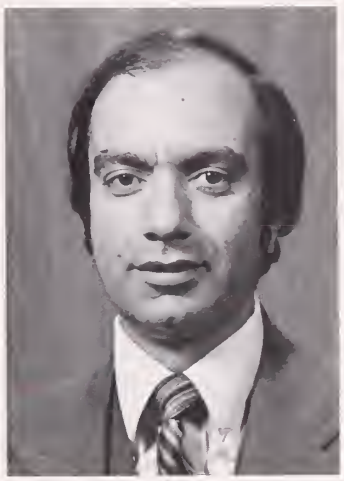
Joseph Ezra Wells Meeting

A NEW DECADE
· 1 9 9 0 ·
Pride in Medicine

Nelson B. Rue, MD
KMA President, Presiding

Tuesday, September 25, 1990
Morning General Session
General Sessions Area — Exhibit Space C — Convention Center

8:30 AM Opening Ceremonies
8:40 AM **"Oxygen Therapy in COPD"**
Muzaffar Ahmad, MD, Cleveland, OH
9:00 AM **"New Vascular Techniques in Neurosurgery"**
L. N. Hopkins, MD, Buffalo, NY
9:20 AM **"Medical Ethics for a New Age in the 1990's"**
Thomas E. Elkins, MD, Ann Arbor, MI
9:40 AM **"Vaccinations: Past, Present, and Future"**
Stanley A. Plotkin, MD, Philadelphia, PA
10:00 AM **Intermission to Visit Exhibits**
10:30 AM **"The Differential Diagnosis of Anxiety and Depression"**
Jeffrey M. Schwartz, MD, Los Angeles, CA
10:50 AM **"Common Surgical Problems in the Intensive Care Unit"**
Lewis M. Flint, MD, New Orleans, LA
11:10 AM **"What's New in Impotence Management"**
Tom F. Lue, MD, San Francisco, CA



Muzaffar Ahmad, MD
Cleveland, OH

Chairman, Department of Pulmonary Disease; Director, Pulmonary Fellowship Program; Director, Fiberoptic Bronschoscopy, the Cleveland Clinic Foundation. Medical education, 1965, Government Medical College, Kashmir University, Srinagar, Kashmir, India. Member, American Thoracic Society and AMA. Fellow, American College of Physicians and American College of Chest Physicians. Author of numerous publications.

L. N. Hopkins, MD
Buffalo, NY

Professor and Chairman of Neurosurgery and Professor of Radiology, State University of New York, Buffalo. MD, 1969, Albany Medical College. Member, American Association of Neurological Surgeons; Congress of Neurological Surgeons; AMA; and Fellow, Cerebrovascular Section of the American Association of Neurological Surgeons; Stroke Council of the American Heart Association; American College of Surgeons; and International College of Surgeons, United States Section. Author of numerous publications.

Ky Chapter, American College of Chest Physicians

Meeting Room 106 — Lower Level — Convention Center
Tuesday, September 25, 1990

1:30 PM **"Silent Ischemia and Nitrate Therapy"**
James M. Atkins, MD, Dallas, TX
2:15 PM **"Beta Blockers and Acute Myocardial Infarction"**
Stuart W. Zarich, MD, Boston, MA
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **"Current Trends in the Treatment of Asthma"**
Muzaffar Ahmad, MD, Cleveland, OH
4:15 PM **"Heart Failure — Present Concepts and Treatment"**
Bruce Brundage, MD, Tarrance, CA
7:00 PM **"Diastolic Dysfunction and Heart Failure"**
Bruce Brundage, MD, Tarrance, CA
Dinner Meeting

Thomas E. Elkins, MD
Ann Arbor, MI

Associate Professor, Chief, Division of Gynecology, Department of Obstetrics and Gynecology, University of Michigan Medical School, Ann Arbor. MD, 1975, Baylor College of Medicine, Houston, TX. Member, American Society of Law and Medicine; National Down Syndrome Congress; American Association on Mental Deficiency; American Colposcopy Society; North American Society for Pediatric & Adolescent Gynecology; and AMA. Fellow; American College of Obstetricians and Gynecologists. Author of numerous publications.

Ky Chapter, American College of Surgeons

General Sessions Area — Convention Center
Tuesday, September 25, 1990

11:30 AM **Council Meeting** (Cherokee/Shawnee Rooms)
12 NOON **Lunch** (Cherokee/Shawnee Rooms)
1:30 PM **"Assessment of Preoperative Risk for Vascular Patients"**
Andris Kazmers, MD, Lexington, KY
2:00 PM **"Operative Treatment of Gallstones—Advances or Retreat"**
Gary C. Vitale, MD, Louisville, KY
2:30 PM **Intermission to Visit Exhibits**
3:00 PM **"The Spleen: Distinguishing History from Hysteria"**
Lewis M. Flint, MD, New Orleans, LA
3:30 PM **"Adjuvant Therapy for Colorectal Carcinoma"**
Daniel E. Kenady, MD, Lexington, KY
4:00 PM **"Transplantation in the Nineties"**
Frederick R. Bentley, MD, Louisville, KY
4:30 PM **"What's New in Medicare"**
James B. Holloway, MD, Lexington, KY

Stanley A. Plotkin, MD
Philadelphia, PA

Director, Division of Infectious Diseases, The Children's Hospital of Philadelphia; Professor of Pediatrics and Microbiology, University of Pennsylvania; Professor, The Wistar Institute of Anatomy and Biology, Philadelphia. MD, 1956, State University of New York College of Medicine, Brooklyn. Member, American Academy of the Advancement of Science; Society for Pediatric Research; American Society for Microbiology; Infectious Diseases Society of America; American Epidemiologic Society; American Association of Immunologists; and American Society for Virology. Author of numerous publications.

Ky OB/GYN Society — Ky Section ACOG

Meeting Room 110 — Lower Level — Convention Center
Tuesday, September 25, 1990

12 NOON Luncheon Meeting (Regency South A)
1:30 PM **"Ethical Issues Surrounding the Advances of Prenatal Care"**
Thomas E. Elkins, MD, Ann Arbor, MI
2:00 PM **"Human Papilloma Virus: Current Status and Future Directions"**
Holly H. Gallion, MD, Lexington, KY
2:30 PM **Intermission to Visit Exhibits**
3:00 PM **"New Concepts in Operative GYN Endoscopy"**
Joseph S. Sanfilippo, MD, Louisville, KY
3:30 PM **"AIDS in Pregnancy: Dilemma Facing Obstetricians"**
W. David Hager, MD, Lexington, KY
4:00 PM **"Umbilical Vein Blood Sampling, Prenatal Diagnosis and Fetal Management"**
Joseph A. Spinnato, MD, Louisville, KY

Ky Pediatric Society

Meeting Room 108 — Lower Level — Convention Center
Tuesday, September 25, 1990

1:30 PM **"Bronchial Asthma: Pathophysiology, Psychodynamics, Current Practice and Controversies"**
Moderator — Stephen J. Pollard, MD, Louisville, KY
Panel — Nemr S. Eid, MD, Louisville, KY
Sandra D'Angelo, PhD, Lexington, KY
Jamshed F. Kanga, MD, Lexington, KY
Kathleen Sheerin, MD, Louisville, KY
2:45 PM **Intermission to Visit Exhibits**
3:15 PM **"Controversies Regarding Immunization"**
Stanley A. Plotkin, MD, Philadelphia, PA
4:00 PM **Report on the Redbook**
Stanley A. Plotkin, MD, Philadelphia, PA
6:00 PM Cocktails (Kentucky Suite)
7:00 PM Dinner (Kentucky Suite)

Jeffrey M. Schwartz, MD
Los Angeles, CA

Assistant Research Professor, Department of Psychiatry and Biobehavioral Sciences, University of California, Los Angeles. MD, 1978, Downstate Medical Center, Brooklyn, NY. Member, American Psychiatric Association; Society for Neuroscience; and Diplomate, American Board of Psychiatry and Neurology. Author of numerous publications.

Lewis M. Flint, MD
New Orleans, LA

Regents Professor and Chairman, Department of Surgery, Tulane University Medical Center, New Orleans; Professor and Chairman, Department of Surgery, School of Medicine and Biomedical Sciences, State University of New York at Buffalo. MD, 1965, Duke University, Durham, NC. Member, American Surgical Association; American College of Surgeons; American Association for the Surgery of Trauma; International Cardiovascular Society; Southern Surgical Association; Southern Association for Vascular Surgery; and AMA. Editorial Board, *Heart and Lung; American Journal of Surgery; Journal of Trauma;* and *Surgery Report* (Editor in Chief). Author of numerous publications.

Ky Psychiatric Association

Meeting Room 107 — Lower Level —
Convention Center
Tuesday, September 25, 1990

1:00 PM General Meeting
1:45 PM **"Diagnosis and Treatment of Obsessive-Compulsive Disorder (OCD)"**
Jeffrey M. Schwartz, MD, Los Angeles, CA
2:30 PM **Intermission to Visit Exhibits**
3:00 PM **"Insurance, Managed Care and Mental Health"**
Robert G. Pope, MD, Louisville, KY
Joyce Hagen, Louisville, KY
Steve Linehan, Louisville, KY
4:30 PM Reception — Vincenzo's
Presentation of Barry Bingham Media Awards

Ky Neurosurgical Society

Meeting Room 109 — Lower Level —
Convention Center
Tuesday, September 25, 1990

1:30 PM **"New Vascular Techniques in Neurosurgery"**
L. N. Hopkins, MD, Buffalo, NY
2:00 PM **"Brain Death and Organ Donation"**
"Organ Donation Process: Separating the Concepts of Brain Death and Organ Donation when Approaching Families"
George H. Raque, MD, Louisville, KY
"Organ Procurement in Kentucky"
Elizabeth L. Reed, KODA, Louisville, KY
2:20 PM **"Acoustic Neuroma — Surgical Treatment"**
Robert G. Ojemann, MD, Boston, MA
2:50 PM **Intermission to Visit Exhibits**
3:00 PM **"Current Trends in Physician Reimbursement"**
Panel Discussion
Moderator: Russell L. Travis, MD, Lexington
"Reimbursement Negotiations"
Charles J. Cronan, IV, Attorney, Louisville, KY
"Past, Present, and Future of Physician Reimbursement"
Byron C. Pevehouse, MD, San Francisco, CA
"RBRVS — Development and Present Status"
Robert G. Ojemann, MD, Boston, MA
"Federal Budget Deficit — Effect on Physician Reimbursement"
Charles Plante, Washington, DC
4:30 PM Discussion
5:00 PM Business Meeting
5:30 PM Cocktail Party
6:30 PM Dinner

Tom F. Lue, MD
San Francisco, CA

Associate Professor, Department of Urology, University of California, San Francisco. MD, 1972, Kaohsiung Medical College, Kaohsiung, Taiwan. Member, Western Section, American Urological Association; International Board Member, Brazilian Society for Impotence Research; International Society of Impotence Research; Society for Impotence Research (USA); Societe Internationale d'Urologie (US Section); AMA; and Fellow, American College of Surgeons. Author of numerous publications.

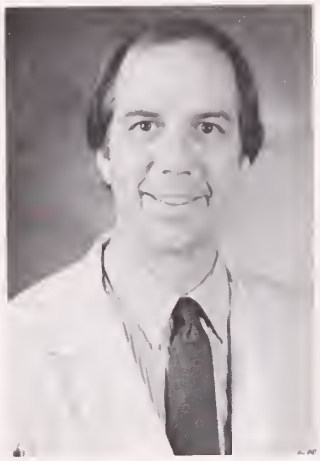
Robert H. Alford, MD
Nashville, TN

Medical Director, Centennial Medical Center, Nashville; Clinical Professor of Medicine, Vanderbilt University School of Medicine, Nashville. MD, 1961, Vanderbilt University. Member, Southern Society for Clinical Investigation; American Society for Microbiology; and American College of Physician Executives. Fellow, Infectious Diseases Society of America and American College of Physicians. Reviewer, *Southern Medical Journal; Journal of Infectious Diseases; Annals of Internal Medicine; Reviews of Infectious Diseases.*

Ky Urological Association

Meeting Room 105 — Lower Level — Convention Center
Tuesday, September 25, 1990

1:30 PM **"Diagnosis and Treatment of Vasculogenic Impotence"**
Tom F. Lue, MD, San Francisco, CA
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **"Pyelogram Hour"**



W. Brian Gibler, MD
Cincinnati, OH

Assistant Professor, Department of Emergency Medicine, University of Cincinnati College of Medicine, Cincinnati. MD, 1981, Vanderbilt University School of Medicine, Nashville, TN. Member, American College of Emergency Physicians; Society for Academic Emergency Medicine; National Association of EMS Physicians; and AMA. Author of numerous publications.

KMA Resident Physicians Section

Oaks Room, Hyatt Regency Hotel
Tuesday, September 25, 1990

12 NOON **Welcome**
W. Ford Threlkeld, MD, Madisonville
KMA-RPS President
12:10 PM **Report on AMA-RPS**
Vaughn Payne, MD, Louisville
AMA-RPS Delegate
12:20 PM **"Student Loan Issues — Deductibility/Deferment"**
Belle Kulick, Chicago
AMA-RPS Policy Analyst
12:45 PM **Lunch**

James R. Gavin, III, MD
Edmond, OK

William K. Warren Professor for Diabetes Studies and Professor of Medicine and Chief of Diabetes Section, University of Oklahoma Health Sciences Center, Oklahoma City. MD, 1975, Duke University, Durham, NC. Member, American Federation of Clinical Research; The Endocrine Society; and American Society for Clinical Investigation. Diplomate, National Board of Medical Examiners and American Board of Internal Medicine. Editorial Board, *American Journal of Medical Sciences*. Author of numerous publications.

James A. Baumgarten, MD, Chairman Scientific Program Committee, Presiding

Wednesday, September 26, 1990
Morning General Sessions
General Sessions Area — Exhibit Space C — Convention Center

8:40 AM Announcements
8:50 AM **"AIDS in the Primary Care Setting"**
Robert H. Alford, MD, Nashville, TN
9:10 AM **"Advances in the Early Diagnosis of Acute Myocardial Infarction"**
W. Brian Gibler, MD, Cincinnati, OH
9:30 AM **"Emerging Trends in Diabetes: A Different Disease in the 1990s"**
James R. Gavin, III, MD, Oklahoma City, OK
9:50 AM **Intermission to Visit Exhibits**
10:20 AM **"Molecular Techniques in Diagnostic Pathology"**
Ronald A. DeLellis, MD, Boston, MA
10:40 AM **"Advances in Plastic Surgery"**
Melvin Spira, MD, Houston, TX
11:00 AM **"Workplace Substance Abuse Programs"**
Robert B. Swotinsky, MD, Washington, DC

President's Installation & Awards Luncheon

Regency Ballroom
Hyatt Regency Hotel

Nelson B. Rue, MD
KMA President, presiding

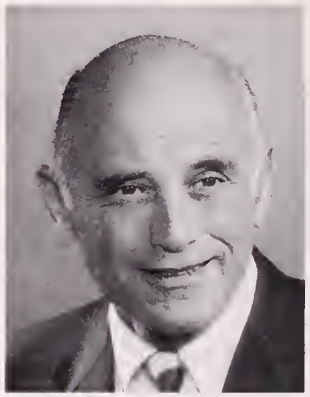
Invocation
Recognition

Awards Presentation
S. Randolph Scheen, MD, Louisville
Chairman, KMA Awards Committee

Installation of new KMA President

Ronald A. DeLellis, MD
Boston, MA

Professor of Pathology, Tufts University School of Medicine; Senior Pathologist, New England Medical Center Hospital, Boston, MA. MD, 1966, Tufts University School of Medicine. Member, American Association of Pathologists; Histochemical Society; and International Academy of Pathology. Editorial Board, *American Journal of Surgical Pathology; Ultrastructural Pathology; Laboratory Investigation; Human Pathology; Modern Pathology;* and *Applied Pathology*. Author of numerous publications.



Melvin Spira, MD, DDS
Houston, TX

Professor and Head, Division of Plastic Surgery, Baylor College of Medicine, Houston. MD, 1956, Medical College of Georgia, Augusta. DDS, 1947, Northwestern University Dental School, Chicago. Member, American Society of Maxillofacial Surgeons; American Society of Plastic and Reconstructive Surgeons, Inc; Southern Medical Association; American Association of Plastic Surgeons; The International Society of Reconstructive Microsurgery; American Correctional Health Service Association; American Society for Aesthetic Plastic Surgery, Inc; and Fellow, American College of Surgeons and American Academy of Dental Medicine.

Ky Chapter, American Academy of Family Physicians

Meeting Room 106 — Lower Level — Convention Center
Wednesday, September 26, 1990

2:15 PM **"Infections in Diabetics"**
Robert H. Alford, MD, Nashville, TN
3:30 PM **Intermission to Visit Exhibits**
4:00 PM **"Hope and Expectations for Ethics and Family Practice in the 90s"**
Gabriel Smilkstein, MD, Louisville, KY

Ky Chapter, American College of Emergency Physicians

Meeting Room 109 — Lower Level — Convention Center
Wednesday, September 26, 1990

2:15 PM **"Advances in the Early Diagnosis of Acute Myocardial Infarction"**
W. Brian Gibler, MD, Cincinnati, OH
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **Semi-Annual Meeting**

Ky Society of Pathologists

Meeting Room 107 — Lower Level — Convention Center
Wednesday, September 26, 1990

2:15 PM **"Immunohistochemistry in Diagnostic Pathology"**
Ronald A. DeLellis, MD, Boston, MA
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **"Immunohistochemistry in Diagnostic Pathology"**
Ronald A. DeLellis, MD, Boston, MA

Robert Swotinsky, MD
Washington, DC

Senior Clinical Associate, Washington Occupational Health Associates, Inc; Clinical Instructor in Medicine, The George Washington University School of Medicine, Washington, DC. MD, 1984, Vanderbilt University, Nashville, TN. Member, American College of Occupational Medicine and National Capital Occupational Medical Association. Author of numerous publications.

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Leo M. Cooney, Jr, MD
New Haven, CT

Humana Foundation Professor of Geriatric Medicine, Yale University School of Medicine; Medical Director, Soundview Specialized Care Center, West Haven; Medical Director, Continuing Care Unit, Yale-New Haven Hospital. MD, 1969, Yale University School of Medicine, New Haven. Member, Committee to Review Quality of Care in the Medicare Program: Institute of Medicine; and President and Member, Board of Directors, American Geriatrics Society. Editorial Board, *Journal of the American Geriatrics Society*. Author of numerous publications.

Ky Chapter, American College of Physicians
Meeting Room 105 — Lower Level — Convention Center
Wednesday, September 26, 1990

2:15 PM **"Managing Diabetes in the 1990s"**
Moderator — David E. Bybee, MD, Louisville, KY
Faculty — James R. Gavin, III, MD, Oklahoma City, OK
Michael A. Pfiefer, MD, Lexington, KY
Debra C. White, RN, Lexington, KY

3:30 PM **Intermission to Visit Exhibits**

4:00 PM **"Managing Diabetes in the 1990s"**
Moderator — David E. Bybee, MD, Louisville, KY
Faculty — James R. Gavin, III, MD, Oklahoma City, OK
Michael A. Pfiefer, MD, Lexington, KY
Debra C. White, RN, Lexington, KY

This presentation consists of formal presentations and case discussions on important aspects in the control of diabetes in the 1990's. The materials have been developed by the American Diabetes Association.

This program is being presented throughout the country in multiple sites to help those involved in the primary care of patients to provide more in-depth care of their patients with diabetes mellitus.

William W. Busse, MD
Madison, WI

Professor, Head, Section of Allergy and Clinical Immunology, Department of Medicine, University of Wisconsin Medical School, Madison. MD, 1966, University of Wisconsin Medical School. Member, American Association of Immunologists; American Federation for Clinical Research; American Thoracic Society; and Fellow, American Academy of Allergy and American College of Physicians. Editorial Board, *Clinical and Experimental Allergy* and *Journal of Respiratory Disease*. Author of numerous publications.

Richard T. Miyamoto, MD
Indianapolis, IN

Professor and Chairman, Arilla DeVault Distinguished Investigator, Department of Otolaryngology-Head and Neck Surgery, Indiana University, Indianapolis. MD, 1970, University of Michigan Medical School, Ann Arbor. Member, American Academy of Otolaryngology-Head & Neck Surgery; American College of Surgeons; American Academy of Facial Plastic & Reconstructive Surgery; American Association for the Advancement of Science; and AMA. Editorial Board, *The Laryngoscope* and *American Journal of Otology*. Author of numerous publications.

Ky Society for Plastic & Reconstructive Surgery

Meeting Room 108 — Lower Level — Convention Center
Wednesday, September 26, 1990

2:15 PM **"Confessions of a Medical Tattoo Artist"**
Raleigh R. Archer, MD, Lexington, KY
2:35 PM **"Distally Based Radial Forearm Pedicle Flap for Coverage of First Web Space Defect"**
Dorothy H. Clark, MD, Lexington, KY
2:55 PM **"Immediate Breast Reconstruction"**
Richard C. Sadove, MD, Lexington, KY
3:15 PM **Intermission to Visit Exhibits**
3:45 PM **"Predicting the Functional Results of Carpal Tunnel Release"**
Bruce A. MacDougal, MD, Madisonville, KY
4:00 PM **"Breast Reduction by the Numbers"**
Melvin Spira, MD, Houston, TX
Residents' Competition — "Topics to be Announced"
University of Louisville
David Mull, MD, Louisville, KY
Randy Proffitt, MD, Louisville, KY
University of Kentucky
Gary Talbert, MD, Lexington, KY
Joseph Minarchek, MD, Lexington, KY

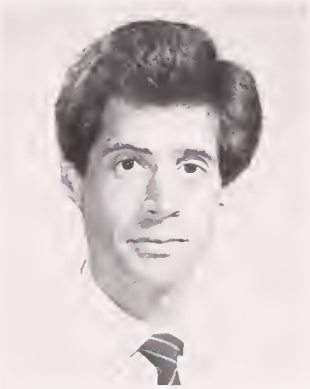
Ky Occupational Medical Association/Ky Association of Public Health Physicians

General Sessions Area — Convention Center
Wednesday, September 26, 1990

2:15 PM **"The Medical Review Officer's Duties and Responsibilities"**
Robert B. Swotinsky, MD, Washington, DC
3:15 PM **Intermission to Visit Exhibits**
3:45 PM **"Occupational Ramifications of AIDS"**
Bob Mullin, MD, Atlanta, GA

Bernard A. Rineberg, MD
New Brunswick, NJ

Clinical Associate Professor in Anatomy and Clinical Associate Professor in Surgery, UMDNJ-Robert Wood Johnson Medical School, New Brunswick, NJ. MD, 1960, Duke University, Durham, NC. Member, American College of Surgeons; American Academy of Orthopaedic Surgeons, Eastern Orthopaedic Association; American Orthopaedic Foot and Ankle Society; International Society of Orthopaedic Surgery and Traumatology; North American Spine Society; American Board of Orthopaedic Surgery; and AMA. Author of numerous publications.



Loren A. Laine, MD
Los Angeles, CA

Assistant Professor of Medicine, Section of Gastroenterology, Department of Medicine, University of Southern California School of Medicine. Affiliate Investigator, Center for Ulcer Research and Education. MD, 1979, UCLA School of Medicine. Member, American Gastroenterological Association and American Society for Gastrointestinal Endoscopy, and Fellow, American College of Gastroenterology. Reviewer, *Gastroenterology; New England Journal of Medicine; Digestive Diseases and Sciences; Gastrointestinal Endoscopy;* and *Annals of Internal Medicine.* Author of numerous publications.

John D. Noonan, MD
KMA Vice President, Presiding

Thursday, September 27, 1990
Morning General Session
General Sessions Area — Exhibit Space C — Convention Center

8:25 AM Announcements
8:30 AM **"Caring for an Aging Population"**
Leo M. Cooney, Jr, MD, New Haven, CT
8:50 AM **"Management of Rhinitis: A Forgotten Disease"**
William W. Busse, MD, Madison, WI
9:10 AM **"Auditory Prostheses for the Deaf"**
Richard T. Miyamoto, MD, Indianapolis, IN
9:30 AM **"Managing Change During Complex Times — A Blueprint For Medical Success in the 1990s**
Bernard A. Rineberg, MD, New Brunswick, NJ
9:50 AM **Intermission to Visit Exhibits**
10:20 AM **"Upper Gastrointestinal Hemorrhage"**
Loren A. Laine, MD, Los Angeles, CA
10:40 AM **"The Ophthalmic Management of Graves Disease"**
Darrell E. Wolfley, MD, New Orleans, LA
11:00 AM **"What's New in Anesthesiology"**
Alan W. Grogono, MD, New Orleans, LA
11:20 AM **"Sunshine in the 90s — The Good, The Bad, and The Ugly"**
Vincent A. DeLeo, MD, New York, NY

Darrell E. Wolfley, MD
New Orleans, LA

Professor of Ophthalmology, Director of Oculoplastic Surgery Service and Residency Training Program, LSU Eye Center, LSU Medical Center School of Medicine. MD, 1969, Northwestern University Medical School, Chicago, IL. Diplomate, National Board of Medical Examiners and American Board of Ophthalmology. Member, American Academy of Ophthalmology; Pan American Association of Ophthalmology; Advisory Board of Directors, American Society of Contemporary Ophthalmology; Charter Member, International Society of Ocular Surgeons; and Fellow, American Society of Ophthalmic Plastic and Reconstructive Surgery. Editorial Board, *Annals of Ophthalmology*. Author of numerous publications.

Ky Geriatric Society

Meeting Room 111 — Lower Level — Convention Center
Thursday, September 27, 1990

1:30 PM **"Back Pain in the Elderly"**
Leo M. Cooney, Jr, MD, New Haven, CT
2:30 PM **"Preoperative Evaluation of the Elderly"**
Kenneth E. Holtzapple, MD, Louisville, KY
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **"Assessment and Management of Pressure Ulcers"**
Leo M. Cooney, Jr, MD, New Haven, CT
4:00 PM First Annual Meeting of the Kentucky Geriatric Society
5:30 PM Reception — Hyatt Hotel — Kentucky Suite
6:00 PM Informal Remarks by Leo M. Cooney, Jr, MD, on the American Geriatric Society
Installation of Officers
Gourmet Dinner — Hyatt Hotel

Alan W. Grogono, MD
New Orleans, LA

Professor and Chairman of Anesthesiology, Tulane University School of Medicine, New Orleans. Medical Education, 1959, University of London Faculty of Medicine, London, England. Diplomate, American Board of Anesthesiology. Member, American Society of Anesthesiologists; Anaesthetic Research Society, England; British Medical Association; International Anesthesia Research Society; Southern Medical Association; Royal Society of Medicine, London; and AMA. Editorial Board, *Literature Scan: Anesthesiology* and *Anesthesiology Review*. Author of numerous publications.

Ky Society of Allergy & Clinical Immunology

Meeting Room 110 — Lower Level — Convention Center
Thursday, September 27, 1990

1:30 PM **"Respiratory Tract Infections and Bronchial Asthma"**
William W. Busse, MD, Madison, WI
2:30 PM **"Hyper IGE Syndrome"**
Kathleen Sheerin, MD, Louisville, KY
3:30 PM **Intermission to Visit Exhibits**
4:00 PM **"To Be Announced"**
Evan N. Massey, MD, Louisville, KY

Ky Dermatological Society

310 E Broadway
Louisville, Ky
Thursday, September 27, 1990

1:00 PM **Case Presentations**
2:00 PM **Case Discussion**
3:00 PM **"The Photosensitivity Patient — Workup and Management"**
Vincent A. DeLeo, MD, New York, NY
4:00 PM Business Meeting
5:00 PM Adjournment
6:30 PM Cocktails and dinner to follow
(Location to be announced)

Ky Academy of Eye Physicians & Surgeons

Meeting Room 108 — Lower Level — Convention Center
Thursday, September 27, 1990

1:30 PM **Presentation of Papers by Members of KY Academy of Eye Physicians and Surgeons**
2:00 PM **"Eyelid Trauma"**
Darrell E. Wolfley, MD, New Orleans, LA
2:30 PM **Intermission to Visit Exhibits**
3:00 PM **Presentation of Papers by Members of KY Academy of Eye Physicians and Surgeons**
3:30 PM **"Orbital Fractures"**
Darrell E. Wolfley, MD, New Orleans, LA
4:00 PM **Business Meeting**

Vincent A. DeLeo, MD
New York, NY

Florence Irving Assistant Professor of Dermatology, College of Physicians and Surgeons, Columbia University, New York; Assistant Dermatologist and Director, Environmental Dermatology Evaluation Unit, Columbia Presbyterian Medical Center. MD, 1969, Louisiana State University School of Medicine, New Orleans. Member, American Academy of Dermatology; American Federation for Clinical Research; American Society of Photobiology and Photochemistry; American Association for the Advancement of Science; Southern Medical Association; and AMA. Editor, *Newsletter,* American Society of Photobiology. Author of numerous publications.

(Program continues on page 442.)

Ky Orthopaedic Society

Meeting Room 107 — Lower Level — Convention Center
Thursday, September 27, 1990

1:00 PM **"The Role of Fibular Transfers in Reconstruction of the Upper Extremity"**
Luis R. Scheker, MD, Louisville, KY

1:15 PM **"Toe to Thumb Transfer — A New Technique"**
Wagar Aziz, MD, Louisville, KY
Tsu-Min Tsai, MD, Louisville, KY

1:30 PM **"Isolated Symptomatic Radial Tears of the Lateral Meniscus on Athletes"**
William Pakan, MD, Lexington, KY
J. Michael Ray, MD, Lexington, KY
Steven J. Meyer, MD, Lexington, KY
Mitch J. Duby, MA, ATC, Lexington, KY

1:45 PM **"Update on the Use of Antibiotic Impregnated Beads in Orthopaedics"**
Stephen H. Henry, MD, Louisville, KY
David Seligson, MD, Louisville, KY

2:00 PM **"Classification and Treatment of Spine Fractures"**
Lorne E. Weeks, III, MD, Lexington, KY

2:15 PM **"Analysis of Treatment Results for Type III-B and III-C Open Tibial Fractures"**
Rolando M. Puno, MD, Louisville, KY
Tsu-Min Tsai, MD, Louisville, KY
James W. Harkess, MD, Louisville, KY
David Seligson, MD, Louisville, KY

2:30 PM **"Intra-operative Autotransfusions in Spinal Surgery: A 5-Year-Update on the Kentucky Experience and Review of the Literature"**
Steven J. Meyer, MD, Lexington, KY
J. Michael Ray, MD, Lexington, KY
David B. Stevens, MD, Lexington, KY

2:45 PM **"Intravenous Regional Anesthesia for Emergency Room Use in the Treatment of Upper Extremity Trauma"**
Martin G. Schiller, MD, Louisville, KY

3:00 PM **Intermission to Visit Exhibits**

3:30 PM **"Status of Recertification and the Position of the American Academy of Orthopaedic Surgeons"**
Bernard A. Rineberg, MD, New Brunswick, NJ

4:15 PM **"Survival Factors and Functional Recovery Following 122 Thumb Replantations"**
Akira Arakaki, MD, Louisville, KY
Tsu-Min Tsai, MD, Louisville, KY

4:30 PM **"Quantitative Analysis of the Upper Extremity Arterial System Via Tri-Flow Color Imaging"**
Milton Pignataro, MD, Louisville, KY
James Kleinert, MD, Louisville, KY
Jerri Anderson, RT, RDMS, Louisville, KY

4:45 PM Business Meeting

5:30 PM Adjournment

6:30 PM Reception/Dinner — Vincenzo's Restaurant — Downtown Louisville

Ky Society for Gastrointestinal Endoscopy

Meeting Room 105 — Lower Level — Convention Center
Thursday, September 27, 1990

1:30 PM **"The Role of Therapeutic Endoscopy in the Management of the Acute GI Bleeder"**
Loren A. Laine, MD, Los Angeles, CA

2:30 PM **Intermission to Visit Exhibits**

3:00 PM **"Cardiopulmonary Monitoring During Endoscopy"**
Daniel B. Hill, MD, Lexington, KY

3:15 PM **"Clinical Application of Echoendoscopy"**
Nicholas J. Nickel, III, MD, Lexington, KY

3:30 PM **"Comparison of APACHE II Classification System and Resting Energy Expenditure"**
Paul E. Brown, MD, Louisville, KY

3:45 PM **"NMR-P31 Spectroscopy and Hepatic Ischemia"**
William F. Marterre, Jr, MD, Lexington, KY

4:00 PM **"Louisville Experience with Biliary Lithotripsy"**
Kenneth R. Kranz, MD, Louisville, KY

4:15 PM **"Mechanisms of Photodynamic Therapy"**
T. Jeffery Wieman, MD, Louisville, KY

4:30 PM **"Experience of Percutaneous Endoscopic Gastrostomy"**
Joseph M. Henderson, MD, Lexington, KY

4:45 PM **"Laparoscopic Cholecystectomy Using KTP Laser"**
Nelson B. Rue, MD, Bowling Green, KY

5:00 PM General Board Meeting

5:15 PM Reception

Ky Society of Anesthesiologists
Meeting Room 106 — Lower Level —
Convention Center
Thursday, September 27, 1990

1:00 PM **"Infections in the OR"**
Alan W. Grogono, MD, New Orleans, LA
1:45 PM **"Fluid Volume Replacement in the High Risk Patient"**
John Hoyt, MD, Pittsburgh, PA
2:30 PM **Intermission to Visit Exhibits**
3:00 PM **"Propofol: An IV Anesthetic Agent"**
Jane D. Lowdon, MD, Atlanta, GA
3:45 PM **"Hemodynamic Responses During Emergence and Extubation"**
Thomas Fuhrman, MD, Columbus, OH
4:30 PM **"Management of Cancer Pain"**
Frank McDonald, MD, Lexington, KY
5:00 PM Business Meeting

Ky Society of Otolaryngology Head and Neck Surgery, Inc.
Meeting Room 109 — Lower Level —
Convention Center
Thursday, September 27, 1990

1:30 PM **"New Concepts in the Management of Neurofibromatosis"**
Richard T. Miyamoto, MD, Indianapolis, IN
2:15 PM **"Nasal Allergies"**
Panel Discussion
Alan B. McDaniel, MD, Louisville
Stephen J. Pollard, MD, Louisville
Robert D. Woods, MD, Lexington
Laurie R. Thomas, MD, Winchester
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **Paper to be Presented**
3:45 PM **Paper to be Presented**
4:00 PM **Paper to be Presented**

CONTINUING MEDICAL EDUCATION

The Kentucky Medical Association designates this continuing medical education activity for 18 credit hours in Category 1 of the Physician's Recognition Award of the American Medical Association. One credit hour may be claimed for each hour of participation by the individual physician.

General Sessions Summaries

Oxygen Therapy in COPD
Muzaffar Ahmad, MD
This presentation will be to review the patient population which will benefit from continuous oxygen therapy and the impact of this therapy on morbidity and mortality. Various techniques of oxygen therapy will be discussed and the cost effectiveness of each emphasized. The audience should have an understanding of the indications of oxygen therapy and the optimum delivery systems.

New Vascular Techniques in Neurosurgery
L. N. Hopkins, MD
To provide participants with a basic understanding of the technique of endovascular surgery. To inform participants of the indications, limitations, benefits and risks of endovascular surgery for vascular and neoplastic central nervous system lesions. To heighten their awareness of the major clinical and economic impacts of endovascular surgery.

Medical Ethics for a New Age in the 1990s
Thomas E. Elkins, MD
To provide better understanding and clearly define the major ethical issues facing medicine in the 1990s; delineate the approaches to ethical decision making that can be useful in the 1990s; list barriers to the development of ethical decision making in the 1990s; and recognize opportunities for teaching ethics that will be relevant in the 1990s.

Vaccinations: Past, Present and Future
Stanley A. Plotkin, MD
To provide better understanding of how much success vaccination has had in the United States and why? Why is revaccination being recommended for measles? What changes may be made in polio vaccine recommendations? What is the status of conjugated Haemophilus influenzae type B vaccines? When will the new varicella vaccine be available? What vaccines are on the horizon?

The Differential Diagnosis of Anxiety and Depression
Jeffrey M. Schwartz, MD
This presentation will cover clinical approaches to the diagnosis of anxiety and depression. Symptom clusters of these two clinical disorders will be described. Methods helpful for differential diagnosis will be presented. Approaches to the treatment of these conditions will be discussed, with a stress on pharmacologic treatment.

Common Surgical Problems in the Intensive Care Unit
Lewis M. Flint, MD
At the conclusion of this presentation the attendees should be able to recognize the multiple organ failure syndrome and be able to understand the common hemodynamic patterns encountered in the intensive care unit. The use of the Swan-Ganz catheter for monitoring should be understood by the attendee as well as the indication and dosage of various drugs.

What's New in Impotence Management
Tom F. Lue, MD
The presentation will give the audiences a brief summary of the exciting advances in the last decade regarding: the physiology of normal penile erection; the goal-directed approach to impotence diagnosis; and the various new treatment options for impotence.

AIDS in the Primary Care Setting
Robert H. Alford, MD
This presentation will review current epidemiology of AIDS, update of infectious complications of AIDS, and definition of which AIDS cases should be taken care of by Primary Care Physicians.

Advances in the Early Diagnosis of Acute Myocardial Infarction
W. Brian Gibler, MD
The physician attending this presentation will be exposed to new methodologies available for the diagnosis of acute myocardial infarction (AMI) in the emergency department, particularly serial CK-MB sampling. Early serum marker determination using immunochemical serial CK-MB sampling substantially improves the likelihood for AMI diagnosis in patients with non-diagnostic ECG. Early detection of AMI in these patients will allow appropriate triage to intensive care settings, prevent unintended discharge of patients with AMI, and potentially identify individuals with non-diagnostic ECGs and AMI who would benefit from thrombolytic therapy.

Emerging Trends in Diabetes: A Different Disease in the 1990s
James R. Gavin, III, MD
To understand the effects that changes in population demographics are having on diabetes prevalence in the US. To understand how lifestyle changes have affected diabetes expression in at-risk populations. To understand the types of management strategies that will be necessary to effectively treat the increasing burden of diabetes in the 1990s and beyond. To review the implications of the published "Standards of Care for Persons with Diabetes" for primary providers.

Molecular Techniques in Diagnostic Pathology
Ronald A. DeLellis, MD
This presentation will review the past several decades having witnessed the development of a remarkable series of advances in cellular and molecular biology, genetics and immunology. Recombinant DNA based technologies for studies of gene structure and expression represent the most recent transfer of basic research information into the setting of the clinical laboratory. Although these technologies are still in their infancy, they have already revolutionized our approaches to the diagnosis of a wide variety of infectious, neoplastic and inherited disorders. This lecture will highlight some of the major contributions of recombinant DNA technology to the modern practice of medicine and pathology and will also explore the extraordinary potential of these methods for the future.

Advances in Plastic Surgery
Melvin Spira, MD
The presentation will include an overview of advances both in research and in clinical plastic surgery of interest to all physicians. Subjects to be covered include wound healing, congenital deformities, maxillofacial injuries, hand surgery and aesthetic surgery.

Workplace Substance Abuse Programs
Robert B. Swotinsky, MD
To provide better understanding of the nature and magnitude of drug abuse in the workplace; the various elements of substance abuse programs; and drug testing's strengths and limitations.

Caring for the Aging Population
Leo M. Cooney, Jr, MD
To provide better understanding of the problems of the medical care and consequences of the graying of our society.

Management of Rhinitis: A Forgotten Disease
William W. Busse, MD
To provide a better understanding of the multiple causes of rhinitis and a logical therapeutic approach to control of symptoms and suppression of complications.

Auditory Prostheses for the Deaf
Richard T. Miyamoto, MD
To familiarize the practitioner with current concepts of hearing loss. To describe current management principles. To describe new technology for the profoundly deaf. To provide results of studies with cochlear implants in deaf adults and children.

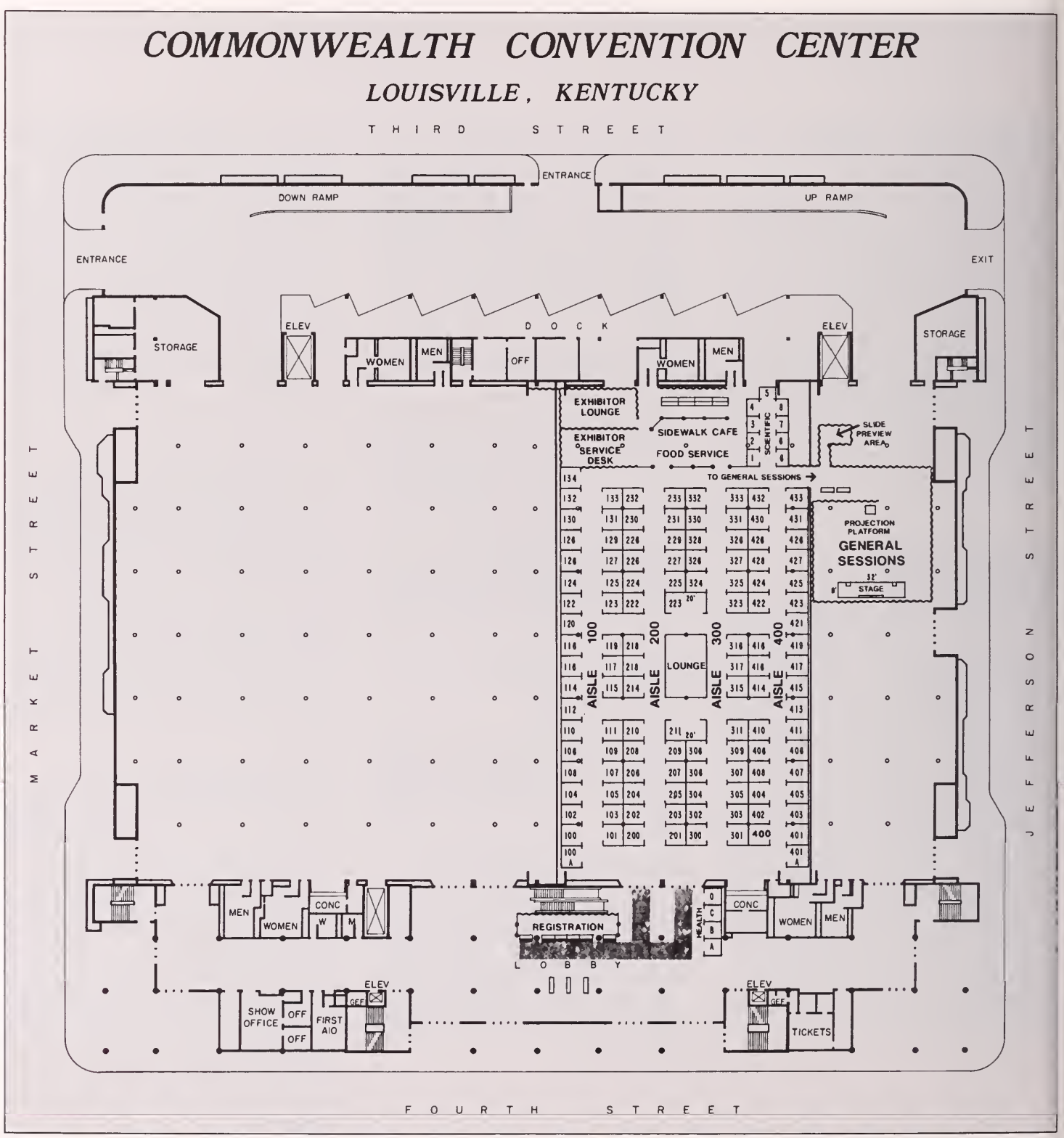
Managing Change During Complex Times — A Blueprint For Medical Success in the 1990s
Bernard A. Rineberg, MD
The participant will be able to demonstrate that there will be opportunities in the 1990s to strengthen the position of the medical practitioner both in the community and with regard to national health policy. The participant will be able to demonstrate that the demand for accountability can work to enhance the position of the health care practitioner and elevate medicine's position in the community.

Upper Gastrointestinal Hemorrhage
Loren A. Laine, MD
The participants will know the diagnostic evaluation, natural history, causes, and current forms of therapy of upper gastrointestinal hemorrhage.

What's New In Anesthesiology
Alan W. Grogono, MD
The participants will obtain an overview of changes in equipment, drugs, and society which appear to be shaping the professional life of the anesthesiologist.

Sunshine in the 90s — The Good, The Bad, and The Ugly
Vincent A. DeLeo, MD
The overall objective of this presentation will be to acquaint a general medical audience with the scientific advances in the last decade, in the area of effects of solar radiation on human skin — both deleterious and beneficial. This will include photo-aging and skin cancer induction as well as photosensitivity. The beneficial effects of radiation as utilized in a therapeutic setting will be presented. The future direction of treatment of the deleterious effects and beneficial use of UV will be discussed including sunscreens and photopheresis.

EXHIBIT HALL FLOOR PLAN



All exhibitors with corresponding booth space(s) are listed on this map of the Exhibit Hall. We regret that due to printing and publication deadlines, not all exhibitors are represented in this Exhibit Guide. For more detailed information on the exhibitors, refer to the Technical Exhibits listing beginning on page 448, and please visit them in the Exhibit Hall.

EXHIBITOR DIRECTORY

Abbott Laboratories
#301

Adria Laboratories
#332

Alliant Health System
#223

Ancom Business Products
#123

Becton Dickinson Primary Care Diagnostics
#111

Beecham Laboratories
#208

Berlex Laboratories, Inc.
#100

Blue Cross and Blue Shield of Kentucky
#210

Bristol Laboratories
#203

Burroughs Wellcome Company
#422

Cardinal Hill Hospital
#329

Caretenders
#102

Carnation Company
#326

Central Pharmaceuticals, Inc.
#233

Charter Hospitals of Kentucky
#205

Ciba-Geigy Pharmaceuticals
#216

Clayton L. Scroggins Assoc. Inc.
#421

Dista Products Company
#325

Dodson Group
#122

Durr Fillauer Medical
#204

EBSCO Reception Room Subscription Services
#419

Eli Lilly and Company
#323

Fisons Pharmaceuticals
#202

Frazier Rehab Center
#132

Fujisawa Pharmaceutical Co.
#229

General Medical Corporation
#222

Glaxo, Inc.
#333

Good Samaritan Hospital
#425

Greentree Applied Systems, Inc.
#104

Grogan's Healthcare Supply
#211

HealthCare Communications
#114

Health Care Excellence, Inc.
#115

Hoechst-Roussel Pharmaceuticals, Inc.
#404

Humana, Inc.
#304

Humana Health Care Plans
#409

ICI Pharmaceuticals Group
#432

Image Technology, Inc.
#207

Insurance Corp. of America
#413

J. Graham Brown Cancer Cen.
#112

Jewish Hospital HealthCare Services
#401A

John Hancock Life Insurance Company
#300

KY Air National Guard
#414

KY Disability Determinations
#430

KY Medical Insurance Co.
#431

KY Organ Donor Affiliates
#411

KY Telco Federal Credit Union
#134

Key Pharmaceuticals
#224

KMA Insurance Agency, Inc.
#429

Knoll Pharmaceuticals
#302

Laboratory Supply Company
#406

Lakeview Rehabilitation Hospital
#403

Marion Merrell Dow Inc.
#428

McNeil Consumer Products Company
#133

MediSense, Inc.
#231

MD Systems
#424

Mead Johnson Nutritionals
#305

Mead Johnson Pharmaceuticals
#303

Medic Computer Systems
#402

Medical Management Resources
#209

The Medical Protective Company
#200

Merck Sharp & Dohme
#106 & 108

Mid-South Medical Book Service
#226

Miles Pharmaceuticals
#317

NTS Corp-Lake Forest CC
#131

National Health Laboratories, Inc.
#116

Neuro Imaging of KY
#128

Norton Psychiatric Clinic
#230

Office Time Savers, Inc.
#330

Olympus Corporation
#401

O.P.T.I.O.N. Care
#227

Ortho Pharmaceutical Corp.
#101

PAM Medical Systems
#109

Parke-Davis
#214

Pfizer Labs
#119

Physio-Control Corporation
#427

PIE Mutual Insurance Co.
#110

Professional Billing Services of KY, Inc.
#130

Professional Telecom, Inc.
#417

Pulse Computer Systems
#408

RANAC Computer Corporation
#206

Ransdell Surgical, Inc.
#405

Reed & Carnrick
#327

Rehabilitation Specialty Center
#306

Rivendell Psychiatric Center
#415

Roerig-Pfizer
#433

Rorer Pharmaceuticals
#232

Ross Laboratories
#407

Russ Pharmaceuticals, Inc.
#328

Saint Anthony Medical Center
#324

Saint Joseph Hospital
#416 & 418

Sandoz Pharmaceuticals
#100A

Searle, G.D. & Company
#315

Sentinel Medical Review Organization
#103

Shearson Lehman Hutton
#307

Skycare
#423

SmithKline Beecham Clinical Laboratories
#319

SmithKline Beecham Pharmaceuticals
#311

Squibb U.S. Pharmaceutical Group
#118

Summit Pharmaceuticals
#309

Ten Broeck Hospital at KMI
#426

UAD Laboratories, Inc.
#308

U. S. Air Force Recruiting
#120

U. S. Army Medical Dept.
#201

U. S. Navy
#331

The Upjohn Company
#218

Upjohn HealthCare Services
#410

Weber Medical
#225

Whitehall Laboratories
#228

Wismer*Martin
#117

Wyeth-Ayerst Laboratories
#400

Exhibit Guide
1990

TECHNICAL EXHIBITS

The Technical Exhibits at the 1990 KMA Annual Meeting will feature the latest developments in medical techniques and information. Located in the Commonwealth Convention Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

Prepared carefully and skillfully to appeal to you, the physician, the exhibits are especially geared to your special interests as a practitioner. Medical representatives and other exhibitors will be on hand to discuss personally their products and services with you. Both you and your patients should benefit from the information that can be gained from a visit to the Technical Exhibits.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this excellent opportunity provided by exhibits.

Abbott Laboratories **#301**
One Abbott Park Road
Abbott Park, IL 60064-3500
(708) 937-7141
Your are cordially invited to visit the Abbott booth which will feature Abbott Vision™ (office diagnostic system), Hytrin® (terazosin HCl), Ogen® (estropipate tablets, U.S.P.), PCE® (erythromycin particles in tablets) and various Abbott products. Please check at the exhibit to see what's new!

Adria Laboratories **#332**
Columbus, OH 43216
(614) 764-8100

Alliant Health System **#223**
200 E Chestnut St
Louisville, KY 40202
(502) 562-8000
Norton Hospital, Kosair Children's Hospital, Methodist Evangelical Hospital. The creation of the Alliant Health System, integrated the Norton Hospital, Methodist Evangelical Hospital and Kosair Children's Hospital. All three hospitals feature superior resources for this region's patients with cancer and diabetes, spine and orthopaedic problems. Also each hospital offers special care centers: Norton features the Women's Pavilion, the Norton Psychiatric Clinic, and the Kenton D. Leatherman Spine Center; Methodist Evangelical offers centers on orthopaedics, diabetes, ophthalmology, and urology; Kosair Children's is the region's only full-serviced pediatric hospital.

Ancom Business Products **#123**
2831 Center Rd/Box 150
Brunswick, OH 44212
(216) 225-1510
Ancom products take stress out of practice management. Color coded filing and accounting systems, professional forms, computer forms, pegboard books, conventional and open-shelf cabinets improve front office efficiency significantly to produce a measurable increase in profitability. Ancom service representatives will be on hand to discuss specific practice management needs, answer questions and offer valuable management tips.

Becton Dickinson **#111**
Primary Care Diagnostics
One Becton Dr
Franklin Lakes, NJ 07417-1882
(201) 848-6734
Stop by the Becton Dickinson Primary Care Diagnostics booth and see the award winning QBC® II PLUS CENTRIFUGAL HEMATOLOGY ANALYZER. Get eight hematology parameters as easy as a spun hematocrit. QBC — the only hematology analyzer designed specifically for the physician's office. Come see in-office diagnostic testing made quick, simple and accurate with Becton Dickinson QTEST™ STREP, and QTEST™ PREGNANCY.

Beecham Laboratories **#208**
501 Fifth St
Bristol, TN 37620
(615) 652-3410
Beecham Laboratories has introduced the first oral and injectable clavulanate antibiotics, Augmentin and Timentin. Due to their unique ability to destroy beta-lactamases, these clavulanate antibiotics offer expanded coverage and activity against an array of bacteria, which in the past have been resistant to cephalosporins and penicillins.

Berlex Laboratories, Inc. **#100**
300 Fairfield Road
Wayne, NJ 07470
(201) 694-4100
Levlen® and Tri-Levlen® oral contraceptives, Deconamine® SR Capsules and Quinaglute® Dura-Tabs®

Blue Cross and Blue Shield of Kentucky **#210**
9901 Linn Station Road
Louisville, KY 40223
(502) 423-2293

Bristol Laboratories **#203**
2400 West Lloyd Expressway
Evansville, IN 47721
(812) 429-5000
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: Corgard (nadolol tablets); K-Lyte/Klotrix (potassium supplement); and Questran Light (cholestyramine for oral suspension).

Burroughs Wellcome Company **#422**
3030 Cornwallis Road
Research Triangle Park, NC 27709-9987
(919) 248-3000

Cardinal Hill Hospital **#329**
2050 Versailles Road
Lexington, KY 40504
(606) 254-5701
Cardinal Hill Hospital in Lexington, KY provides physical rehabilitation services to persons of all ages. Physical, occupational, and speech therapy; psychiatry; occupational medicine; psychology services; nursing and social services meet the needs of the whole patient and family system. Specialized programs include head injury, stroke, orthopedic, neuromuscular, amputee, chronic pain, arthritis, spinal cord, pediatric, work hardening, evaluation and clinics, and preschool. Both inpatient and outpatient services offered.

Caretenders **#102**
9200 Shelbyville Road, Suite 220
Louisville, KY 40222
(502) 425-4701
Home nursing, home infusion therapy, home medical equipment.

Carnation Company **#326**
5045 Wilshire Blvd
Los Angeles, CA 90036
(213) 932-6062
The Carnation Company invites you to Booth #326 to share information on our infant nutritional products. Good Start is the well-tolerated nutritionally complete starter formula. For older babies 6 to 12 months of age, Follow-Up Formula provides complete nutrition for the transitional diet. On site professional education materials will be available.

Central Pharmaceuticals, Inc. **#233**
120 E Third St
Seymour, IN 47274
(812) 522-3915

Charter Hospitals of Kentucky **#205**
435 Berger Road, PO Box 7609
Paducah, KY 42002-7609
(502) 444-0444
Charter Hospitals of Kentucky are located in Lexington, Louisville, and Paducah. Owned by Charter Medical Corporation, Charter Hospitals of Kentucky are JCAH accredited, full service psychiatric hospitals. Charter maintains both outpatient and inpatient, chemical dependency and psychiatric care for adults, adolescents, and children.

Ciba-Geigy Pharmaceuticals **#216**
5587 Dove Lane
West Chester, OH 45069
(513) 779-9116

Clayton L. Scroggins Associates, Inc. **#421**
200 Northland Blvd
Cincinnati, OH 45246
(513) 771-7070
Management consulting and income tax planning for doctors exclusively. Assisting doctors with the business of medical practice. Impartial counsel in a professional, comprehensive and confidential manner on a fee for service basis. Services throughout Kentucky, Ohio and Indiana.

Dista Products Company **#325**
Lilly Corporate Center
Indianapolis, IN 46285
(317) 276-2554
You are cordially invited to visit the Dista Products Company exhibit. Our sales representatives in attendance will welcome your questions about our pharmaceutical products. Our featured products will be Keftab™ (cephalexin hydrochloride monohydrate, Dista) and Prosac® (fluoxetine hydrochloride, Dista).

Dodson Group **#122**
9201 State Line
Kansas City, MO 64114
1-800-825-3760
Information for Workers' Compensation insurance dividend program.

Durr Fillauer Medical **#204**
3332 Powell Ave
Nashville, TN 37202
(615) 383-9100

EBSCO Reception Room Subscription Services **#419**
PO Box 830460
Birmingham, AL 35283
1-800-527-5901
EBSCO Reception Room Subscription Services saves physicians up to 50% off the regular subscription prices for waiting room magazines and also provides subscriptions to professional journals. By using EBSCO, physicians can make one annual purchase a year for all waiting room and professional journals. We also have magazine binders and magazine racks available for waiting areas.

Eli Lilly and Company **#323**
Lilly Corporate Center
Indianapolis, IN 46285
(317) 276-2554
Eli Lilly and Company welcomes the opportunity to support your organization through participation in your exhibit program. We cordially invite you to visit our display and discuss any inquiries you may have concerning Ceclor® (cefaclor, Lilly), Humulin® (human insulin of recombinant DNA origin, Lilly) and Axid™ (nizatidine, Lilly).

Fisons Pharmaceuticals **#202**
Box 1766
Rochester, NY 14603
1-800-234-5535
Fisons Pharmaceuticals is committed to making available high quality health care products and services to all who would benefit from them. Fisons is responsible for much research in the area of allergy . . . and has been a world leader in the areas of allergy and asthma. We are also proud to present other excellent products used to treat symptoms of cough/cold as well as hypertension. Please take the opportunity to visit our booth and meet our representatives. We join you in your commitment to improve health care.

Frazier Rehab Center **#132**
220 Abraham Flexner Way
Louisville, KY 40202-1886
(502) 582-7400
Frazier Rehab Center is dedicated solely

to the rehabilitation of people with disabilities such as head and spinal cord injuries, strokes, amputations, pulmonary conditions, and other orthopedic and neurologic disorders. The health care system includes a 95-bed hospital in the heart of the Louisville Medical Center and a network of outpatient centers conveniently located throughout Kentuckiana. Frazier's treatment programs center on a multi-disciplinary team approach designed to maximize each person's physical, mental, and social abilities.

Fujisawa Pharmaceutical Company **#229**
10401 W Touhy Ave
Rosemont, IL 60018-3392
1-800-888-7704
Fujisawa Pharmaceutical Company is very pleased to be in attendance at this year's convention. Although Fujisawa is not new to the United States, this is the first year to be a participant. Fujisawa features CEFIZOX, a third generation injectable cephalosporin and VAGISTAT. VAGISTAT is the only single dose ointment that cures vulvovaginal candid in most patients. Fujisawa also now has sole responsibility for ARISTOCORT and ELASE. Please stop by our booth for more information.

General Medical Corporation **#222**
11112 Decimal Dr
Louisville, KY 40299
(502) 267-8311

Glaxo, Inc. **#333**
8601 Six Forks Road, Suite 504
Raleigh, NC 27615
(919) 848-6158

Good Samaritan Hospital **#425**
310 S Limestone
Lexington, KY 40508-3008
(606) 252-6612

Greentree Applied Systems, Inc. **#104**
629 N. Broadway
Lexington, KY 40508
(606) 254-6388
The Medistar-90 Computer System represents a complete accounts receivable system for the modern medical office. Designed in the 90's to meet the needs of the 90s medical office, it includes electronic claims submission, HMO/IPO support, statements, etc. Runs on personal computers and is multi-user. Prints HCFA 1500 and UB82 forms.

Grogan's Healthcare Supply **#211**
1016 S Broadway
Lexington, KY 40504
(606) 254-6661
Displaying the latest examination and laboratory equipment from top manufacturers, and providing up-to-date information on laboratory reimbursement and medical waste regulations.

HealthCare Communications **#114**
182 Market Place Blvd.
Knoxville, TN 37922
(615) 970-1659
HealthCare Communications and Apple® Computer's Macintosh family of computers have joined together to offer MediMac™. MediMac™ is the leader in medical office automation. MediMac™ has been successful because it takes full advantage of all the features that have made the Macintosh not only one of the most powerful, but also the most easily operated microcomputers ever built. Dollar for dollar, no other system compares with MediMac™ for power and ease of operation.

Health Care Excellence, Inc. **#115**
PO Box 2089
Elizabethtown, KY 42701
(502) 737-5111
Health Care Excellence is a consulting and marketing firm that specializes in building medical practices by promoting excellence rather than through blatant advertising. Founded by successful health care practitioners, the company assists physicians in promoting a positive image by "communicating care and concern" for patients. Health Care Excellence's communication tools and techniques can bring you more patients and develop strong referral networks.

Hoechst-Roussel Pharmaceuticals, Inc. **#404**
Routes 202-206
Somerville, NJ 08876-1258
(201) 231-2727
Trental® (pentoxifylline) is the only proven effective agent for the treatment of intermittent claudication symptomatic of peripheral arterial disease (PAD). Trental® has been shown to improve red cell flexibility and lower blood viscosity. Stop by the Hoechst-Roussel Pharmaceuticals, Inc. exhibit for important new information concerning Trental.®

Humana, Inc. **#304**
500 W Main St
Louisville, KY 40202
(502) 580-3571

Humana Health Care Plans **#409**
101 Prosperous Place, Suite 300
Lexington, KY 40509
606-263-1400

ICI Pharmaceuticals Group **#432**
Wilmington, DE 19897
1-800-441-7758

Image Technology, Inc. **#207**
141 Prosperous Place, Suite 22B
Lexington, KY 40509
(606) 263-7777
PARADIGM Medical Management Software is a comprehensive data process-

ing solution for medical billing, accounting, patient tracking, and practice management. PARADIGM uses the latest data base technology to provide the user with the speed and power required by today's large data bases. At the same time, PARADIGM is very easy to learn and use. Since PARADIGM was developed on the UNIX™ operating system, it runs on most platforms available. This portability provides the end user with investment protection for his software and peripherals, while providing nearly unlimited growth potential.

Insurance Corporation of America **#413**
4295 San Felipe, Suite 300
Houston, TX 77027
(713) 871-8100
Insurance Corporation of America provides professional liability coverage to physicians and surgeons nationwide. The company markets through independent agents, is based in Houston, Texas, and has regional offices in Seattle and St. Louis.

James Graham Brown Cancer Center **#112**
529 S Jackson St
Louisville, KY 40202
(502) 588-6905

Jewish Hospital HealthCare Services **#401A**
217 E Chestnut St
Louisville, KY 40202
(502) 587-4914
Physicians in private practice are facing a radically different health care environment with ever increasing competition for patients. Jewish Hospital offers a comprehensive program to help physicians build their private practice and manage it more effectively. Some of the services provided to our physicians include: associate recruitment, practice management services, office automation systems, community education and involvement, office staff seminars, market surveys, and patient communications. Information will be available describing recruitment enhancement programs.

John Hancock Life Insurance Company **#300**
725 Wicklow Road
Louisville, KY 40207
(502) 896-8993
Sales and service to all the physicians that I have sold insurance to. W.E. "Red" Davis.

Kentucky Air National Guard **#414**
Standiford Field
Louisville, KY 40213-2678
(502) 364-9424
The Kentucky Air National Guard is a reserve component of the Air Force. It offers physicians and other medical professionals the opportunities to serve their state and nation in a unique way. You also receive good pay, benefits, retirement and valuable training that will enhance your career.

Kentucky Disability Determinations **#430**
PO Box 1000
Frankfort, KY 40601-0001
(502) 564-7450
The treating physician is the most significant provider of medical information for the disability claimant. Without the first-hand medical data, which deals with the signs, symptoms and clinical findings, the Social Security Administration is unable to make a valid decision relative to the claimant's allegations. We appreciate your willingness to be a vital part of this process.

Kentucky Medical Insurance Company **#431**
3532 Ephraim McDowell Dr
Louisville, KY 40205
(502) 459-3400
Kentucky Medical Insurance Company, organized by the Kentucky Medical Association, is a professional liability insurance company owned by physicians, run by professionals, with physician input in all areas in which there is need of physician expertise. We welcome the opportunity to discuss the advantages and benefits represented by our program of coverage.

Kentucky Organ Donor Affiliates **#411**
305 W Broadway, Suite 316
Louisville, KY 40202
(502) 581-9511
Our booth will display educational materials for physicians regarding organ/tissue donation. In addition, there will be patient information brochures regarding donation.

Kentucky Telco Federal Credit Union **#134**
3740 Bardstown Road
Louisville, KY 40218
(502) 459-3000
The KMA Credit Union. Offer your staff a fringe benefit that won't cost you a cent! Kentucky Telco is a federal credit union with service centers located in Louisville, Lexington and Owensboro, all delivering full financial services with federally insured savings, low cost loans, interest bearing checking, credit cards, Quest ATM, 24-hour telephone service, and discount brokerage. Kentucky Telco is proud to be the only financial institution endorsed by the Kentucky Medical Association.

Key Pharmaceuticals **#224**
2000 Galloping Hill Road
Kenilworth, NJ 07033
(615) 822-6326

KMA Insurance Agency, Inc. **#429**
8134 LaGrange Road, Suite 100
Louisville, KY 40222
(502) 429-6273

Knoll Pharmaceuticals **#302**
30 N Jefferson Road
Whippany, NJ 07981
(201) 887-8300
Knoll Pharmaceuticals cordially invites you to visit our booth for information on Isoptin® SR (verapamil HCl), the first once-daily calcium channel blocker approved for the management of essential hypertension and Vicodin® (hydrocone bitartrate [5 mg. warning: May be habit forming] and acetaminophen 500 mg.) and our Vicodin® ES (hydrocone bitartrate [7.5 mg warning: May be habit forming] and acetaminophen 750 mg.) for moderate to moderately severe pain.

Laboratory Supply Company, Inc. **#406**
4444 Park Blvd
Louisville, KY 40209
(502) 363-1891/1-800-292-9453

Lakeview Rehabilitation Hospital **#403**
134 Heartland Dr
Elizabethtown, KY 42701
(502) 769-3100
Lakeview Rehabilitation Hospital is a 40-bed general medical rehabilitation hospital in Elizabethtown, Kentucky. We have specialized therapeutic programs for stroke, head injury, coma, pulmonary diseases, ventilator weaning, chronic pain management, neurological disorders, and orthopedic injuries. We serve disabled and injured people of all ages with inpatient and outpatient services such as: Neuropsychology, Occupational Therapy, Physical Therapy, Rehabilitation Nursing, Respiratory Therapy, Speech Pathology, and Work Hardening.

Marion Merrell Dow Inc. **#428**
9300 Ward Parkway
Kansas City, MO 64114
(816) 966-4000
Please stop by and let our representatives answer your questions regarding our products. Featured will be CARAFATE® (sucralfate), our unique, non-systemic drug for the treatment of duodenal ulcers; CARDIZEM® SR (diltiazem HCl) sustained release capsules for treatment of hypertension; and SELDANE® (terfenadine) for relief of seasonal allergic rhinitis.

McNeil Consumer Products Company **#133**
1411 Opus Place, Suite 656
Downers Grove, IL 60515
(708) 969-2772
McNeil Consumer Products Company invites you to visit our exhibit, featuring TYLENOL® acetaminophen products, and other fine McNeil products. EXTRA-STRENGTH TYLENOL® GELCAPS and CAPLETS will be higlighted, together with other TYLENOL® products, including JUNIOR-STRENGTH TYLENOL® CAPLETS. Also available will be literature introducing our new Rx liquid ibuprofen product PEDIAPROFEN™, the PediaCare® line of symptom-specific children's cold products, IMODIUM A-D® (loperamide hydrochloride), an anti-diarrheal, and DELSYM® (dextromethorphan polistirex), a 12-hour cough suppressant. Professional samples, information aids, and patient education materials will be available as a service to the health-care profession. We encourage your attendance at our exhibit.

MediSense, Inc. **#231**
4880 Pleasant Grove
Lexington, KY 40515
(606) 272-2580
We are exhibiting the "EXACTECH BLOOD GLUCOSE MONITORING SYSTEM." "EXACTECH" is the smallest and easiest monitor to test blood glucose in your office or for patient's home use.

MD Systems **#424**
1170 E Broadway
Louisville, KY 40204
(502) 589-3207
MD Systems is the most unique office computer systems available. It was developed and written by George C. Stege, III, MD, a Louisville physician, who understands your specific needs. You need a system that is easy to use and understand, and is geared to your specialty; you should consider MD Systems. Consider the options. A system too complicated for your staff and not customized to your practice, or MD Systems. Designed for the MD by an MD.

Mead Johnson Nutritionals **#305**
2400 West Lloyd Expressway
Evansville, IN 47721-0001
(812) 429-7348
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: Enfamil®, Nutramigen®, Poly-Vi-Flor®, ProSobee®, and Tempra®.

Mead Johnson Pharmaceuticals **#303**
2400 West Lloyd Expressway
Evansville, IN 47721
(812) 429-5000
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: BuSpar (buspirone HCl); Desyrel (trazodone HCl); and Duricef (cefadroxil).

Medic Computer Systems **#402**
8601 Six Forks Road, Suite 300
Raleigh, NC 27615
(919) 847-8102
MEDIC Computer Systems provides both hardware and software support to medical practices.

Medical Management Resources **#209**
10200 Linn Station Road #270
Louisville, KY 40223
(502) 423-0793
Provider of choice for electronic claim submission and related technological services within the health care industry. Products are designed for needs rang-

ing from point-of-sale devices for lower volume submitters to fully configured office automation systems for the larger practice.

The Medical Protective Company **#200**
PO Box 15021
Fort Wayne, IN 46885
(219) 485-9622
With ninety years experience in professional protection exclusively, The Medical Protective Company continues to provide unexcelled professional liability defense for physicians.

Merck Sharp & Dohme **#106 & 108**
West Point, PA 19486
(215) 661-5000

Mid-South Medical Book Service **#226**
924 Saundersville Ferry Road
Mt. Juliet, TN 37122
(615) 758-7753
Provides current editions of medical books from most of America's prominent publishers. Serving physicians and other health professions. Books for all clinical specialties.

Miles Pharmaceuticals **#317**
6805 Tottenham Road
Louisville, KY 40207
(502) 897-2033
Miles Pharmaceuticals invites you to stop by our exhibit where our representatives will be pleased to provide information on our products: CIPRO, MEZLIN, MYCELEX-TROCHE, and NIMOTOP. Miles Pharmaceuticals — A major therapeutic force in health care products.

NTS Corporation-Lake Forest Country Club **#131**
511 Woodland Drive
Louisville, KY 40045
(502) 245-4653

National Health Laboratories, Inc. **#116**
4500 Conaem Drive
Louisville, KY 40213
(502) 456-4700
NHL clinical labs headquarters located in LaJolla, CA.

Neuro Imaging of Kentucky **#128**
914 Dixie, Suite 204
Elizabethtown, KY 42701
(502) 769-0313
To promote services for EEGs and Topographical Brain Mapping, including evoked potentials. These services will include telephonic EEG transmission as well as conventional testing.

Norton Psychiatric Clinic **#230**
P.O. Box 35070
Louisville, KY 40232-5070
(502) 562-8850
The Norton Psychiatric Clinic of the Norton Hospital is a 48-bed unit specializing in adolescent, adult, and geriatric psychiatry in a medical-surgical hospital. While affiliated with the University of Louisville, the programs there have achieved regional and national recognition for excellence in multi-disciplinary treatment. The units offer simultaneous evaluation and treatment of both psychiatric and medical diagnosis.

Office Time Savers, Inc. **#330**
PO Box 2142
Elizabethtown, KY 42702
(502) 737-2991
Space saving filing equipment featuring Supreme Equipment and Systems, Inc.; Supreme's bifile T.M. will be on display; color code labels; super prices on pegboard supplies; free filing survey offered.

Olympus Corporation **#401**
1805 Cross Gate Lane
Louisville, KY 40222
(502) 426-9370
Please stop at the booth and say "Hi!" We will be showing the new concept in VIDEO ENDOSCOPY SYSTEM! The EVIS 100 Endoscopic Video Information System is a revolutionary new videoscope system. Olympus — the full line endoscopy company!

O.P.T.I.O.N. Care **#227**
1794 Bryan Station Road
Lexington, KY 40505
(606) 293-6655
O.P.T.I.O.N. Care provides state of the art home IV and nutritional services. We offer a reliable source for skilled pharmacy, medical equipment, supplies, patient education, delivery, and reimbursement management. O.P.T.I.O.N. Care is a nationwide network of over 180 offices providing uniformly high quality home infusion therapies. We provide a comprehensive range of services including total parenteral nutrition, enteral nutrition, cancer chemotherapy, IV antibiotic therapy, hydration and electrolyte therapy, pain management, and on-call 24-hour service.

Ortho Pharmaceutical Corporation **#101**
Route 202, PO Box 300
Raritan, NJ 08869
(201) 218-6943
Ortho Pharmaceutical Corporation will present the most complete line of medically accepted products for the control of conception. The country's first and most frequently prescribed oral contraceptive, ORTHO-NOVNUM 777™, will be featured along with other available oral contraceptive dosages and regimens. The newest vaginal antifungal preparation, TERAZOL™, will also be featured complimenting a variety of other vaginal therapeutic medications. Numerous patient and professional educational aids will be available for review.

PAM Medical Systems **#109**
147 S Broadway
Georgetown, KY 40324
(502) 863-6044
Many general practice physicians and specialists experience office inefficiences and reduced cash flow resulting from the myriad of record keeping required to satisfy insurance companies and local/state/federal health care agencies. The PAM medical inter-office computer system provides true multi-tasking solutions to the daily tasks associated with billing, insurance processing, and

patient tracking. The PAM system is a certified Medicare electronic claims submitter.

Parke-Davis **#214**
201 Tabor Road
Morris Plains, NJ 07950
(201) 540-3182
We invite you to visit the Parke-Davis booth where our sales representatives welcome the opportunity to discuss with you our product, Lopid®. We hope you will join us.

Pfizer Labs **#119**
235 E 42nd Street
New York, NY 10017
(502) 339-1442

Physio-Control Corporation **#427**
150 E Wilson Bridge Rd, Suite 115
Worthington, OH 43085
(614) 885-0216
Physio-Control is a medical equipment company providing unique medical devices of the highest quality, which predict or urgently intervene in life-threatening, cardiorespiratory events.

The PIE Mutual Insurance Company **#110**
9300 Shelbyville Rd, Suite 1001
Louisville, KY 40222
(502) 339-7431
The PIE Mutual Insurance Company of Cleveland, Ohio now offers Kentucky physicians the advantages of an insurance program that has made it the leading professional liability carrier in Ohio. Direct physician involvement in the Company's operations, through regional managing boards, allows PIE to offer an innovative program of insurance that provides stable rates while rewarding loss-free physicians with scheduled premium reductions beginning in the second year of coverage.

Professional Billing Services of KY, Inc. **#130**
1515 Ring Road
Elizabethtown, KY 42702-2547
Promotion for services, including medical billing and practice management data.

Professional Telecom, Inc. **#417**
13145 Middletown Industrial Blvd
Louisville, KY 40223
(502) 244-5800
Voice messaging for the busy professional saves costs, can eliminate telephone tag and keep the physician in touch with his or her patients. Also available are state-of-the-art telephone systems for physicians offices regardless of size.

Pulse Computer Systems **#408**
420 NW 5th Street
Evansville, IN 47708
(812) 428-6750
Pulse will display office management computer systems and software (the Resident by Wallaby).

RANAC Computer Corporation **#206**
8925 N Meridian St, Suite 201
Indianapolis, IN 46260
(317) 844-0141
RANAC's comprehensive software package CompreMED™ is designed to enhance the efficiency of a medical practice. The basic package consists of patient demographic information, billing, accounts receivable, practice analysis, practice marketing, and electronic mail. Options include electronic claims, clinical information, report generator, appointment scheduling, open item, accounts payable, payroll, general ledger, and letter writer. CompreMED™ is available on the IBM PS/2, IBM compatibles, and can accommodate any size practice from the single practitioner to large clinics.

Ransdell Surgical, Inc. **#405**
752 Barret Ave
Louisville, KY 40204
(502) 584-6311

Reed & Carnrick **#327**
One New England Ave
Piscataway, NJ 08855
(201) 981-0070
Reed & Carnrick, serving the medical profession for over 100 years, produces a line of well-established specialty items which are leaders in the fields of cardiology, gastroenterology, gynecology, hypertension, proctology, and dermatology.

Rehabilitation Specialty Center **#306**
191 W Lowry Lane
Lexington, KY 40503
(606) 278-5716
Rehab services available through Comprehensive Outpatient Rehabilitation Facility (CORF). Staffing and equipping rehab facilities.

Rivendell Psychiatric Center **#415**
200 Rivendell Dr
Bowling Green, KY 42101
(502) 843-1199
Rivendell Psychiatric Center is a hospital for children between the ages of 5 and 18 who are having serious emotional and behavioral problems. Children are treated within a therapeutic environment while they participate in individual, group, and family activities, and attend school.

Roerig-Pfizer **#433**
2400 W Central Road
Hoffman Estates, IL 60196
(312) 381-9500
Roerig has two new products. Diflucan, a new antifungal agent, and Cardura, a new anti-hypertensive. Data and literature will be provided by Hugh Runner, Jim Morgan, Jim Michael, Mark Beauchamp, Carey Rochester, Michele Chapman, Bonnie Kiefer, Brad Leighty, Jacque Cobb, and Barry Campbell.

Rorer Pharmaceuticals **#232**
500 Virginia Dr
Fort Washington, PA 19034
(215) 628-6000
We are pleased to be a part of this medical meeting and welcome your visiting our exhibit. Representatives will be available to discuss pharmaceuticals manufactured by Rorer Pharmaceuticals, including Lozol®, Calcimar®, Nitrolingual® Spray, Slo-bid™, and Azmacort®.

Ross Laboratories **#407**
625 Cleveland Avenue
Columbus, OH 43215
(614) 227-3333

Russ Pharmaceuticals, Inc. **#328**
22 Iverness Center Pkwy, Suite 400
Birmingham, AL 35242
(205) 995-5000
Complete line of narcotic analgesics for mild to moderately severe pain in both liquid and tablet form.

Saint Anthony Medical Center **#324**
1313 Saint Anthony Pl
Louisville, KY 40204
(502) 627-1790

Saint Joseph Hospital **#416 & #418**
One Saint Joseph Dr
Lexington, KY 40504
(606) 278-3436
The largest hospital in central and eastern Kentucky, Saint Joseph Hospital serves as a major referral center for the state. Founded in 1877 as the first hospital in Lexington, Saint Joseph has grown to a 468-bed medical complex, constantly expanding and enhancing services to meet the needs of Kentucky's patients and physicians.

Sandoz Pharmaceuticals **#100A**
59 Route 10
East Hanover, NJ 07936
(201) 503-8005
Sandoz Pharmaceuticals invites you to stop by our exhibit where our representatives will be pleased to provide information on our products and on any educational materials that we have available.

Searle, G.D. & Company **#315**
5200 Old Orchard Road
Skokie, IL 60077
(708) 470-3829
Calan® SR (Verapamil HCL), Kerlone® (betaxolol HCL), Cytotec® (Misoprostol).

Sentinel Medical Review **#103**
10503 Timberwood Cir, PO Box 23540
Louisville, KY 40223
(502) 339-7442
Sentinel Medical Review Organization is the Indiana/Kentucky physician-directed Peer Review Organization (PRO) that contracts with the Federal Government to oversee the medical care provided to Medicare and CHAMPUS beneficiaries.

Shearson Lehman Hutton **#307**
200 S Fifth St, Suite 100 North
Louisville, KY 40202
(502) 561-4012
Complete financial services with a specialization in retirement plan management.

Skycare **#423**
217 E Chestnut St
Louisville, KY 40202
(502) 587-4788
SKYCARE continues its leadership role of providing top quality emergency medical services through its Agusta 109-MK II helicopter. Its twin engine offers this area safety previously unavailable. The 180 m.p.h. cruise speed makes the Agusta the fastest helicopter of its kind available for aeromedical transport. Rapid transport, quality pre-hospital and inter-hospital care are the basis of the program. At SKYCARE, our excellent reputation for quality is constantly demonstrated by our commitment to meeting your needs.

SmithKline Beecham Clinical Laboratories **#319**
2277 Charleston Dr
Lexington, KY 40505
(606) 299-3866
Clinical laboratory services.

SmithKline Beecham Pharmaceuticals **#311**
PO Box 7929, E-22
Philadelphia, PA 19101
(215) 751-3668
Representatives will be on hand to answer your specific questions and to provide information on our products and services.

Squibb U.S. Pharmaceutical Group **#118**
PO Box 4500
Princeton, NJ 08543
(609) 243-6218
Squibb U.S. Pharmaceutical Group, innovators in cardiovascular and antimicrobial medicine, invites you to visit our exhibit where our representatives will be happy to discuss the latest advances in these therapeutic areas.

Summit Pharmaceuticals **#309**
Morris Ave
Summit, NJ 07054
(502) 896-0753
Summit Pharmaceuticals, a division of Ciba-Geigy, is proud to present TransDerm Nitro, Actigall, Slow K, and Ten K at the KMA exhibit this year. Our representatives will be available to provide technical information and answer questions about these products. We extend to you an invitation to stop by and visit with us.

Ten Broeck Hospital at KMI **#426**
8521 LaGrange Road
Louisville, KY 40242
(502) 426-6380
Ten Broeck Hospital at KMI is a 94-bed private psychiatric hospital located in eastern Jefferson County on 97 acres of park-like countryside. Ten Broeck offers state of the art treatment for adolescent and adult chemical dependency problems and psychiatric illnesses. Free assessments and consultations are provided at physicians' offices and at hospitals. For information or assistance contact Intake at (502) 426-6380 or (800) 866-TURN.

UAD Laboratories, Inc. **#308**
PO Box 10587
Jackson, MS 39289
(601) 372-7773
UAD will show Lorcet Plus, the strongest Class III pain medication on the market; Zone A Forte, over 2 ½% Hydrocortisone 1% Pramoxine for topic and contact dermatitis; and Endal Tablets, the no-antihistamine, no-drying product, for sinus and congestion.

United States Air Force Recruiting **#120**
2620 Elm Hill Pike, Suite 415
Nashville, TN 37214-3159
(615) 889-0723-0732

United States Army Medical Department **#201**
5111 Leesburg Pike, Suite 638
Falls Church, VA 22041-3258
(703) 756-8124

United States Navy **#331**
600 Dr Martin Luther King Jr Pl, Rm 1058
Louisville, KY 40202
(502) 582-5174
The Navy Medical Corps is a group of physicians who provide medical care to active duty Navy and Marine Corps personnel, their families, and retirees. The Navy Medical Corps is for the physician looking for a professional life with steady advancement, variety, and challenge; a profession in which your medical skills play a vital role in the future of our nation; a profession that keeps you attuned to high-tech medical advances, and that offers you financial rewards, opportunities for career development, and excellent benefits.

The Upjohn Company **#218**
600 Vine St, Suite 2704
Cincinnati, OH 45202
(513) 723-1010

Upjohn HealthCare Services **#410**
850 Breckinridge Lane #270
Louisville, KY 40207
(502) 895-4213
Upjohn has been a leading provider of home health care for more than 20 years. In choosing Upjohn, you receive assurance that the care we provide measures up to the standards of quality established by The Upjohn Company more than a century ago. Upjohn provides a complete range of health care professionals from registered nurses to home health aides, physical and occupational therapists, speech pathologists and medical social workers.

Weber Medical **#225**
1217 Valley Dr
Louisville, KY 40213
(502) 636-2550
Spirometry and Holter monitor specialists. Spirometry systems from Medical Equipment Designs. Holter monitor systems from Advanced Medical Products. Both with proven accuracy, prestigious client lists, and state-of-the-art technology. Both instruments perform as standalone units, or work together as a combination. Offering levels from basic to top-of-the-line. Professional assistance and support provided by highly trained representatives. Both systems R&D, production, and distribution directly by the manufacturers.

Whitehall Laboratories **#228**
685 Third Ave
New York, NY 10017-4076
(212) 878-5073
Whitehall Laboratories, a Health Care Division of American Home Products Corporation, is one of the world's leaders in research and development, manufacture, and marketing of over-the-counter medications and personal care products. Leading Whitehall brands include analgesics such as Advil, Children's Advil, CoAdvil cold and sinus medication, the Dristan line of cold products, as well as Primatene asthma remedies and Preparation H hemorrhodial products. Whitehall also markets a line of family planning products which includes Today Sponge, Clearblue Easy Pregnancy Test, and Clearplan Ovulation Predicator Test Kit.

Wismer*Martin **#117**
135 Technology Pkwy, Suite 200
Norcross, GA 30092
(404) 368-1919
Wismer*Martin, endorsed by the Southern Medical Association, is a leading provider of automated practice management systems. Wismer*Martin provides a complete turnkey system including hardware, software, training, installation, and after sale support. The system operates on IBM and compatible equipment. It provides complete billing and insurance requirements, word processing and other accounting tools.

Wyeth-Ayerst Laboratories **#400**
PO Box 8299
Philadelphia, PA 19101-1245
(215) 971-5612
Please visit the Wyeth-Ayerst Laboratories exhibit and our representatives will be happy to discuss Inderal, Orudis, Premarin and other Wyeth-Ayerst products and services of interest to you.

Contributor Recognition

We wish to thank the following organizations for their special contribution to this year's Annual Meeting:

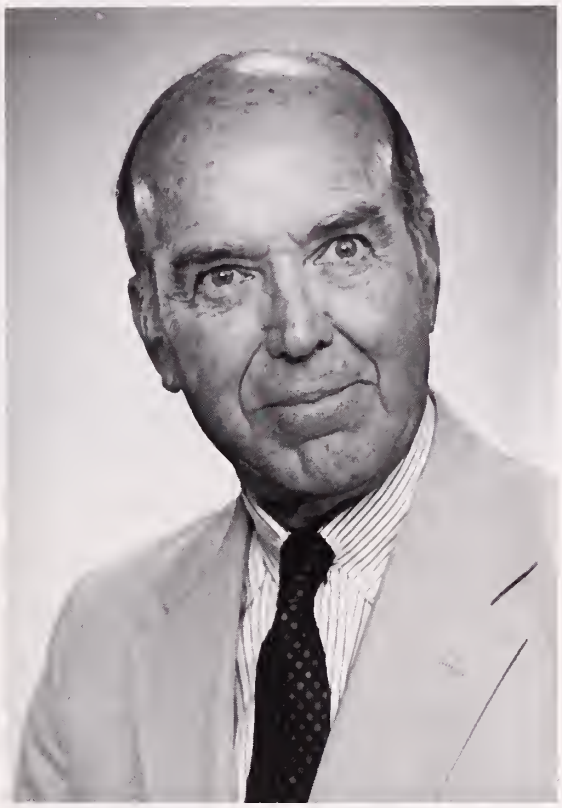
Lederle Laboratories
Janssen Pharmaceutica
The UpJohn Company

S. Randolph Scheen, MD, Nominated for KMA President-Elect

S. Randolph Scheen, MD, has been nominated by the Jefferson County Medical Society for the office of President-Elect of the Kentucky Medical Association.

Dr Scheen's extensive service to KMA began in 1967 when he was elected Secretary. In 1975, the offices of Secretary and Treasurer were combined, and Dr Scheen has served in the capacity of Secretary-Treasurer since that time. He also is currently Chairman of the Awards Committee and a member of the Budget Committee, Judicial Council, and the Ad Hoc Committee on Professional Liability Insurance. He has served on the boards of the Kentucky Medical Insurance Company (KMIC) and KMA Insurance Agency, Inc, since their inception in 1979. Dr Randy Scheen's many years of dedicated service to the association and organized medicine earned him KMA's highest honor, the Distinguished Service Award, in 1977.

A native of Louisville, Dr Scheen received a bachelor of science degree from the University of Louisville, followed by a medical degree from the University of Louisville School of Medicine in 1953. He served his internship at the former St Joseph Infirmary, Louisville; completed a residency in dermatology at Louisville General Hospital; accomplished a fellowship in dermatology at Mayo Clinic in 1957-59; and earned a master's degree in dermatology from the University of Minnesota in 1960. Dr Scheen is in the private practice of dermatology in Louisville and is an Assistant Clinical Professor at the University of Louisville School of Medicine and the University of Kentucky College of Medicine. He also serves on the Admissions Committee of the University of Louisville School of Medicine.



Long active in organized medicine, Dr Scheen in a past Vice-President of the Jefferson County Medical Society, and is also a member of the American Academy of Dermatology, Alumni Foundation of Mayo Clinic, and a regular participant on local television and radio programs. He has served for an extended period as a member of the Advisory Council to the Kentucky Board of Nursing.

Dr Scheen and his wife, Betty, have five children and reside in Louisville. *kma*

Continuing Medical Education

L to R, Sue Ann Capizzi, Illinois State Medical Society; Winston P. Caine, MD, Chattanooga, TN; Larry P. Griffin, MD, Chairman, CME Committee.

On May 22, CME Committee Chairman, Larry P. Griffin, MD, the Committee and KMA staff met with a survey team from the Accreditation Council for Continuing Medical Education (ACCME) as part of the process for KMA's review and recognition as the authorized accrediting agency for the state. Two years ago KMA underwent an intensive review by the ACCME and was awarded recognition for two years. Results from this recent survey will be made available to KMA in the fall. The following organizations are now accredited:

Central Baptist Hospital, Lexington
Good Samaritan Hospital, Lexington
King's Daughters' Medical Center, Ashland
Lexington Clinic, Lexington
Louisville Area CME Consortium, Louisville
Saint Joseph Hospital, Lexington
Saints Mary and Elizabeth Hospital, Louisville
Saint Elizabeth Medical Center, Edgewood

kma

Choosing a Health Plan

One of the problems with health insurance that physicians continually hear about from their patients is that patients aren't sure what types of coverages they should buy and many times find out after they have purchased a plan that it contains a number of exclusions or benefit limitations.

The Kentucky Medical Association has developed the following guide which we hope will aid individuals in their decision making process regarding health insurance.

Please feel free to remove this page and reproduce it as you feel appropriate. We hope you will find this information useful.

What You Should Ask About Your Health Insurance

- May I choose my physician?
- Is my current physician a member of the plan?
- Will my prescription be paid?
- Are x-rays covered by the plan?
- Are office visits covered? Shots (injections)?
- Can I freely choose to see a specialist or must I be referred by my primary physician?
- Does my primary physician control access to specialty consultation?
- May I choose my hospital?
- Will lab tests be paid?
- Will specialists' services be covered?
- Must I have certain surgical procedures done as an outpatient?
- Will I be screened by medical personnel other than a physician before I see my doctor?
- Do I have easy access to a physician on week nights and weekends?
- Will my health care plan cover me for cost of medical treatment at out-of-town facilities when I travel?
- Will dependents be covered if they reside out-of-state?
- Can I get medical advice from a physician over the telephone during nonoffice hours?
- Am I limited to a certain number of routine care appointments?
- Must I schedule my appointments for routine care far in advance?
- Are any illnesses excluded from the coverage?
- May I request a "second opinion" from an outside physician? If so, will I have to pay for it?
- Will I have to pay a deductible or partial payment?
- When and how often are premium rates subject to change?
- Can I be let go from the plan without advance warning or if I use it too much?
- Do I have to fill out claim forms or will my doctor/hospital do that?
- May I use local physicians and hospitals or must I use those approved by the plan, even if I have to go to another community?
- Is my physician required to obtain permission from the plan before services are rendered?
- Will I be covered for urgent care if it is not rendered in a hospital associated with my health care plan?
- What happens if my physician ceases to be a participant in the plan while I am under his/her care?

Basic Health Care Plans

Fee-for-service is the traditional manner of receiving and paying for medical care. **You** choose your physician, hospital, and any other medical care you need. You are charged for the care you receive. Often, your care is paid for through a health insurance company whose premiums may be paid by employers. You may pay a deductible (an amount you must pay before your insurance company begins paying for your health care), or a co-payment (you pay a portion of the bill and the insurance company pays the balance).

Health Maintenance Organization (HMO)

An HMO is an organization that provides health care to a group of persons for a pre-determined price. An HMO offers broad coverage at a fixed price. The prepaid fee stays the same for a given period of time, usually one year regardless of the amount of health care used. That fee may be paid by you or, in full or in part by an employer, government or some other sponsor. In some HMOs, services are offered only at specific locations by groups of physicians and other health care personnel. You are required to use the HMO facility and staff to receive medical care.

Independent Practice Association (IPA)

An IPA is a type of HMO. Physicians practice in their office and care for both IPA subscribers and other patients. IPAs are formed by physicians who enter into agreements, usually with an employer group or insurance company, to provide medical services to that group's employees. Since the IPA is an HMO, the patient still must choose a particular group of physicians and a specific medical facility from which to receive medical services.

Preferred Provider Organization (PPO)

A PPO is a group of health care providers who agree to provide services to a specific group of patients (usually employment based groups) at an agreed upon rate.

A Word of Caution

Keep in mind that there are many different types of HMOs, PPOs, IPAs, and other insurance plans being offered today. Each of them has specific restrictions as to the type of care you receive, where you receive it and from whom. Before joining any plan, or before changing your current medical plan, learn as much as possible about the options being offered to you. Ask for written information which outlines the pluses and minuses of each option and read it carefully. Before you make a final decision, discuss the options with your personal physician to make certain that you will be able to receive the care you need under the option you choose.

Finally...

You should realize that many employers choose a plan for their employees. You may not have a choice. However, the information and questions contained in this article will, at the very least, make you more aware of your current health care plan.

Your physician is the best person to help you understand what's happening in medicine today. If you have questions about any subject mentioned here, we encourage you to ask your physician.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

WESTERN KENTUCKY — Seeking physicians for evening and weekend coverage in a low volume emergency department. Attractive schedule and compensation. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc, 2240 South Airport Road, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

INTERNAL MEDICINE — FAMILY PRACTICE — Excellent private practice opportunity in western Kentucky to join another physician in a busy practice. Competitive compensation package with shared call coverage. Send CV to: Don Hoit, 11222 Tesson Ferry Rd, Suite 203, St. Louis, MO 63123, or call-1-800-336-3963.

HEALTH FRAUD TELECAST
ON KET
MONDAY NIGHT, AUGUST 27, 1990
with
JOHN RENNER, MD

columnist and vice-president of the
NATIONAL COUNCIL AGAINST HEALTH FRAUD,
will be guest panelist on the
THIS IS KENTUCKY, live, call-in KET series!

AN INVITATION

For a chance to visit with your Annual Meeting Exhibitors, join us each morning (Tuesday, Wednesday, & Thursday) in the Lounge area, located in the center of the Exhibit Hall, from 7:45 am - 8:30 am, for free coffee & danish.

Make Your Reservations Now

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 24-27. The Hyatt Regency Louisville will be the Headquarters Hotel (Phone (502) 587-3434). In making your reservations, remember the first House of Delegates meeting will be Monday, September 24. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate.

AUGUST

18-25 — "Comprehensive Review in Internal Medicine" Conference; Hyatt on Capitol Square, 75 E State St, Columbus, Ohio. Sponsored by The Ohio State University Hospitals Department of Internal Medicine. Fees: $750 for the full week if registered before June 15; participants must register for a minimum of four days at $550. Approved for 77.5 Category I Continuing Medical Education credit hours. Contact: Ohio State's Internal Medicine Department — (800) 752-8606.

SEPTEMBER

7-9 — "Aging & Mental Illness," Stouffer Nashville Hotel/Convention Center, Nashville, TN. Presented by the Tennessee Geriatric Society and The Tennessee Psychiatric Association. Contact: James S. Powers, MD, President-Elect TGS, Assistant Professor of Medicine, Vanderbilt University Medical Center, Nashville, TN 37232-5305, 615-322-5000.

15 — "Estrogen and Breast Cancer," University Hospitals' Rhodes Hall Auditorium, Columbus, OH. Contact: Ohio State's Center for CME, (800) 492-4445.

21-22 — "Fifth Annual Encodurietherapy Symposium: New Techniques in Adjuvant Therapy of Cancer," Ohio State University Hospitals' Rhodes Hall Auditorium, Columbus, OH. Contact: Ohio State's Center for CME, (800) 492-4445.

22 — "Ophthalmic Insights into the 90s." Presented by N. D. Radtke, MD and Humana Hospital Audubon. The conference qualifies for 3.5 hours in Category I of the AMA Physicians Recognition Award. Contact: N. D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217, (502) 636-2823.

28-29 — Fifth Annual Multispecialty Oculoplastic Surgery Symposium. A cojoint symposium by all specialties involved with the management of problems of the midface and ocular adnexa to discuss the state of the art solutions to the difficult situations in the realm of oculoplastic surgery. Contact: Karen Heidorn, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 North Eagle Creek Drive, Lexington, KY 40509, (606) 268-3754.

OCTOBER

14-17 — Southern Medical Association's 84th Annual Scientific Assembly, The Opryland Hotel, Nashville, TN. Contact: Kathy McLendon, Communications & Marketing Assistant, SMA, PO Box 190088, Birmingham, AL 35219-0088, (205) 945-1840.

NOVEMBER

1-3 — "Clinical Allergy for the Practicing Physician" — Sponsored by Washington University School of Medicine. Program Chairman: Phillip E. Korenblat, MD. AMA Category I approved — hours to be determined. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 South Euclid, Box 8063, St. Louis, MO 63110; (800) 325-9862, (314) 362-6893.

9-10 — 24th Annual Newborn Symposium and 4th Fall Symposium of the Kentucky Pediatric Society, The Seelbach, 500 Fourth Ave, Louisville, KY. Contact: Lynette McInnis, 502/588-5329.

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LOUISVILLE

SEPTEMBER 24 & 26 MEETINGS OF THE HOUSE OF DELEGATES

SEPTEMBER 25, 26, 27 GENERAL SCIENTIFIC SESSIONS

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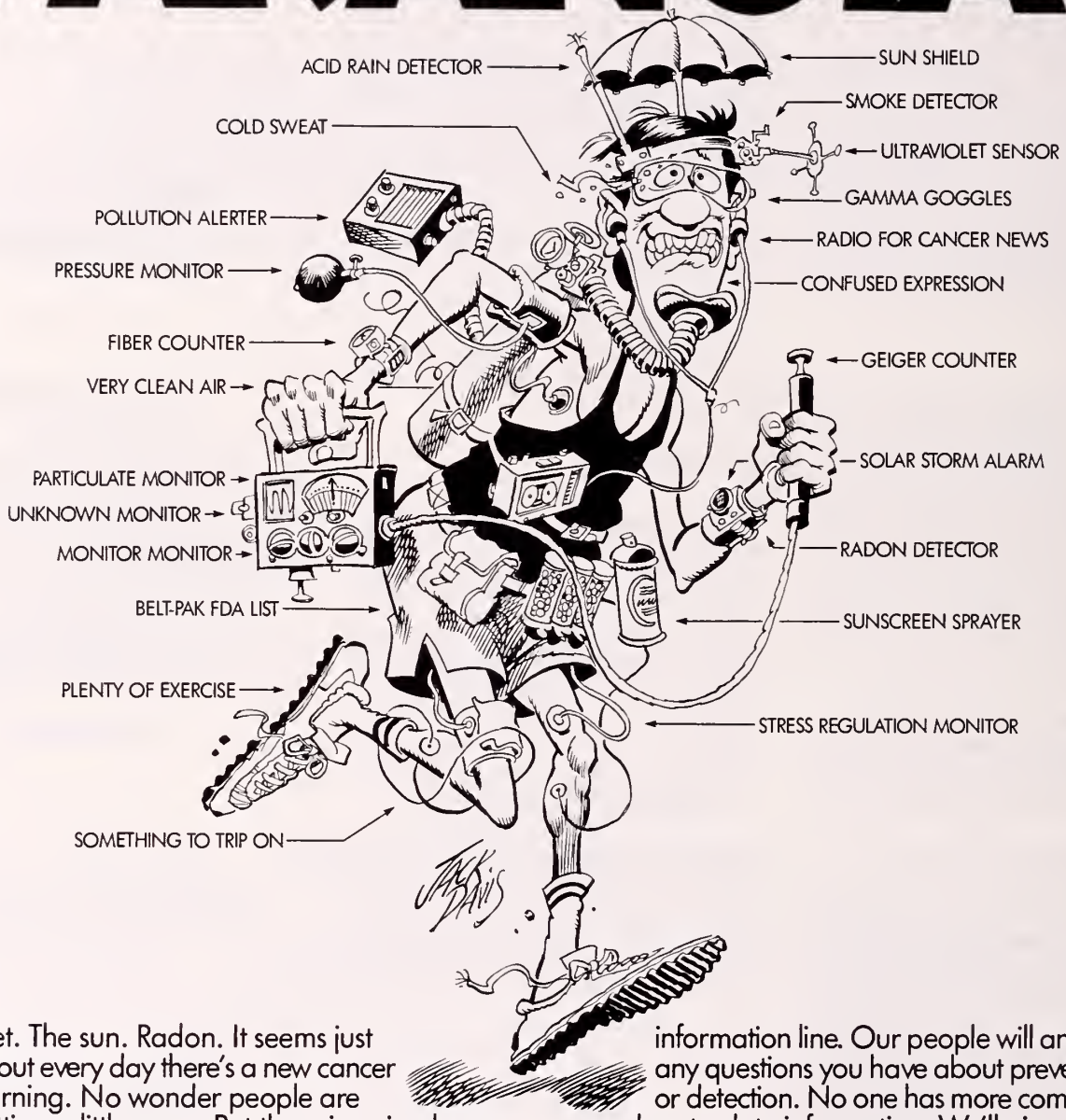

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VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema.* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia. Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy – Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome: Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION. The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE. The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest, myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema, rhythm disturbances, atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J9VS61R2(819)

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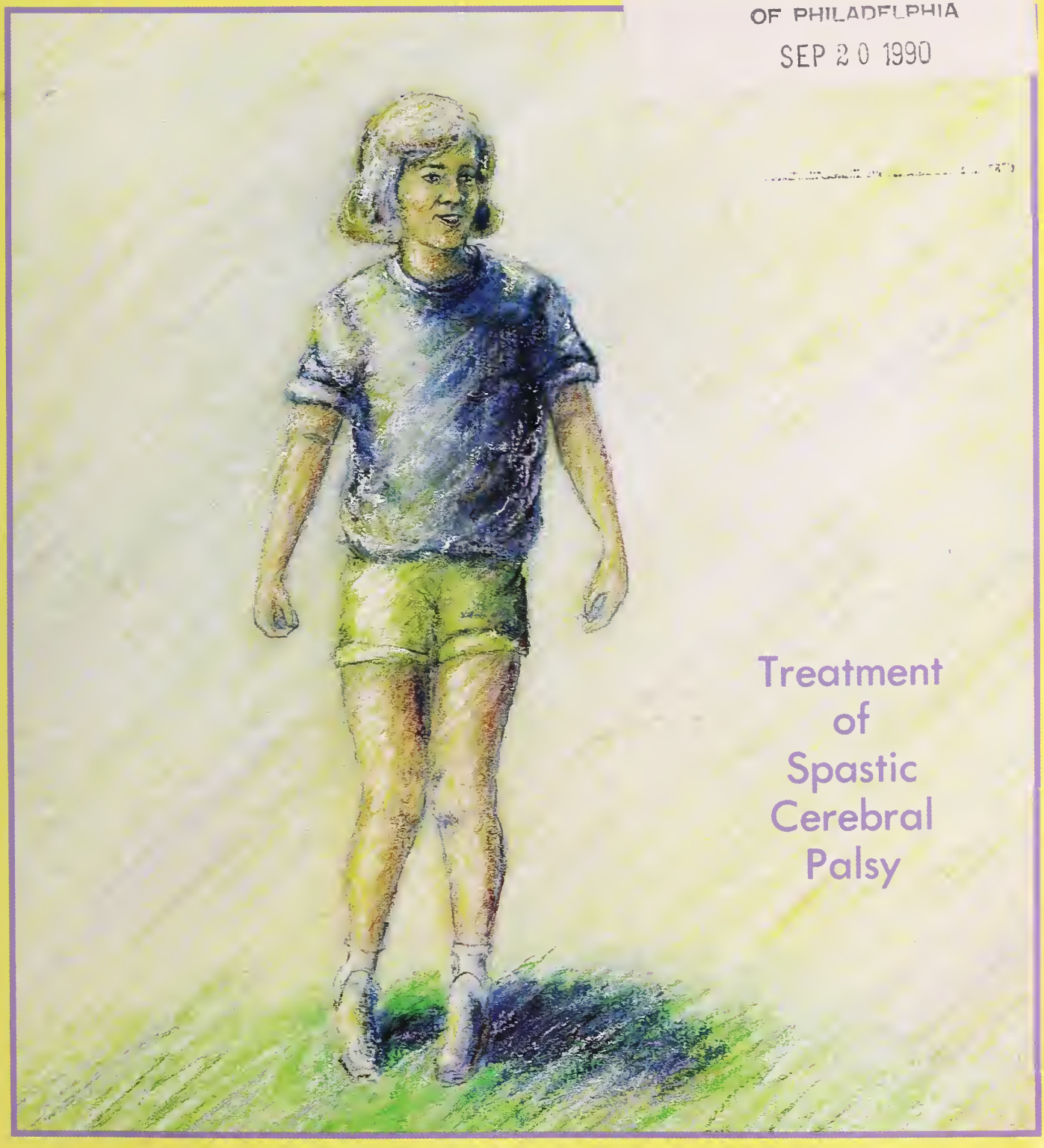

Treatment of Spastic Cerebral Palsy

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***COVER:** Our poignant cover illustration of a child with spastic cerebral palsy introduces a related article on page 482. Original artwork by Lee Wade of Louisville.*

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A Backward Glance

A few weeks ago I caught myself humming "Auld Lang Syne." I was not thinking of New Year's Eve, but of the final days of my year as the 139th President of the Kentucky Medical Association with the same mixed feelings accompanying any year's end. It has been a memorable time for us in many ways and a real learning experience. I want, in my final remarks for the "President's Page," to share some thoughts with you about the progress made this past year and about our trips within and outside this beautiful Commonwealth. I hope you will better understand the complexity of the work done by KMA staff and leadership and by the American Medical Association to represent *you* as Kentucky physicians. This is not an easy task in an era of increased public demands for change in our health care system, while we endure ever-increasing government control and burdensome "hassles" in the daily care of our patients.

I would be remiss if I did not mention here the untimely death from lung cancer in June of my partner of 24 years in the practice of general surgery, Dr Henry N. Meiers, Jr. His coverage these past six years and that of Dr William F. M. Daniel, have made it possible for me to hold office. Their efforts are much appreciated, as are those, beginning in August, of our newest partner Dr Stephen B. Self. State medical association presidents spend on the average 75 to 80 days away from their patients. Obviously, this could not be done without loyal partners. I also wish to thank the fine administrative staff of Graves-Gilbert Clinic in Bowling Green.

'Once again I urge each of you to become involved in organized medicine. You can see that it requires time and effort. It is no longer enough to say that we liked things better the way they were 20 years ago, stick our heads in the sand, and leave the fate of the profession we love in the hands of a few. It is your future! It is my belief that good, strong, aggressive, enthusiastic, positive leadership is our best hope for American medicine.'

One of the greatest pleasures of the office of President is attending the annual meetings of adjacent state associations. We have attended two Ohio meetings — 1989 in Dayton and 1990 in Cleveland. We have also attended the Indiana meeting in Indianapolis, the Virginia meeting in Richmond, the Illinois meeting in Chicago,

and just last month, the West Virginia meeting in White Sulphur Springs. In addition to enjoying warm hospitality and making good new friends, there is a widened perspective gained from the exchange of ideas. We, of course, share many common problems; yet each state has its own particular social, economic, and legislative concerns.

'I cannot emphasize too strongly the value of meeting in a cordial, informal setting with our legislators at these Trustee District dinners. The legislators gladly speak and answer questions in these groups, and valuable rapport is established.'

In Virginia, for example, approximately 80% of medical care is still provided by rural doctors in small rural communities often several miles from a hospital. As older rural doctors retire or die, it is virtually impossible to replace them. There is an acute shortage of young physicians willing to live in and serve these rural areas. In West Virginia the State Legislature passed a bill earlier this year which was *very* unpopular with physicians. Its provisions, . . . "for all health insurance programs involving state dollars, force all doctors to accept as payment in full whatever the state bureaucracy decides is a fair value for their services; with the possibility of stiff criminal penalties for any violations. Furthermore, any doctor who declines to 'participate' in this 'system' is not allowed to receive *any* compensation whatsoever for services rendered to any patient eligible for any of the included insurance programs, even if the patient could pay out of his own pocket."[1]

Fortunately, the Kentucky General Assembly was more sympathetic to the causes of medicine in its 1990 session. Of the 31 issues the Kentucky Medical Association House of Delegates mandated, 31 resolutions were introduced; and *18* passed. These included a comprehensive AIDS bill allowing much wider use of HIV testing to protect health care workers, the Living Will and Surrogate bills, and several vehicle safety measures. The Omnibus Health Care Bill, sponsored by Senator Benny Ray Bailey of Hindman, seeks to address the issues of access to care. The 1990 General Assembly devoted more of its time than usual to health care issues, primarily the CON or so-called "Humana Bill." The full impact of this legislation is not yet known. We feel that the 11 Wednesday meetings KMA's Quick Action and Legislative Affairs Committees held in Frankfort with our lobbying staff were very productive. In addition, KMA officers were called upon to testify before several legislative committees. We feel that testimony before the House Committee hearing regarding the proposed "Nurse Practitioners' Right to Prescribe" was influential in defeating this proposal.

In addition to the weekly Frankfort meetings during the Session, I have traveled to KMA Headquarters in Louisville for numerous meetings, as well as to Health Care Access Foundation Meetings in Lexington. In December 1989, we attended the AMA Interim Meeting in Honolulu, Hawaii, and in February 1990, the American Medical Association National Leadership Conference and Communication Skills Workshop in Phoenix, Arizona. In June we participated in the Kentucky Bar Association's Annual Meeting in Lexington, and later that month attended the American Medical Association Annual House of Delegates Meeting in Chicago, where each state president was recognized. Every effort has been made to represent the interests of Kentucky physicians and to contribute to these sessions and to the resolutions adopted. Your AMA

'I hope you will better understand the complexity of the work done by KMA staff and leadership and by the American Medical Association to represent you as Kentucky physicians. This is not an easy task in an era of increased public demands for change in our health care system, while we endure ever-increasing government control and burdensome "hassles" in the daily care of our patients.'

delegates worked diligently for you, as did KMA staff and other officers.

It was my personal pleasure to address the annual meeting of the Auxiliary to KMA in Owensboro in May. The fine auxilians in Kentucky helped make possible a record-breaking gift of more than $2 million to AMA-ERF this year. The Auxiliary is a vital part of our work for the causes of organized medicine.

I have participated as well in KYCANS — the Kentucky Coalition to Address the Nursing Shortage, the organizational meetings of the Committee for Health Education in the Public Schools (a cause I heartily support), and the Coalition to Address Teenage Pregnancy in Kentucky. I have driven across Kentucky from Bowling Green to Paducah and to Pikeville and Ashland, to Kenton County in northern Kentucky, to Elizabethtown, and to Fayette County for remarks to KMA Trustee District Meetings. In December we drove through snow to Richmond for a Trustee District meeting with their area legislators at a special holiday dinner and program. I also spoke in August to our own 6th District Trustee dinner in Bowling Green. I cannot emphasize too strongly the value of meeting in a cordial, informal setting with our legislators at these Trustee District dinners. The legislators gladly speak and answer questions in these groups, and valuable rapport is established. The Legislative Seminar held by KMA in Frankfort at the beginning of each session of the General Assembly is also very helpful, with legislative leadership speaking to our group about their issue positions. I am even more convinced now than when I took office last September that the legislative arenas, state *and* federal, are our most vital battlegrounds.

In recapping the important events of this KMA year, I must include the work of Dr Russell Travis, who, along with Bill Applegate of KMA Staff and Lt Governor Brereton C. Jones, negotiated with Pfizer Pharmaceuticals to obtain use of their entire line of products at no cost for one year to patients eligible for Kentucky Physician's Care Program. This program for indigent care has brought recognition to Kentucky from medical leaders across the nation. I urge those of you who are not participating to do so.

'We feel that the 11 Wednesday meetings KMA's Quick Action and Legislative Affairs Committees held in Frankfort with our lobbying staff were very productive. In addition, KMA officers were called upon to testify before several legislative committees. We feel that testimony before the House Committee hearing regarding the proposed "Nurse Practitioners' Right to Prescribe" was influential in defeating this proposal.'

I want to thank you once again for the privilege of serving as KMA President this year and for the opportunity to witness firsthand some of the changes in our profession as they have occurred. Once again I urge each of you to become involved in organized medicine. You can see that it requires time and effort. It is no longer enough to say that we liked things better the way they were 20 years ago, stick our heads in the sand, and leave the fate of the profession we love in the hands of a few. It is your future! It is my belief that good, strong, aggressive, enthusiastic, positive leadership is our best hope for American medicine.

I am, of course, leaving to my successor, Dr Preston Nunnelley, a challenging schedule for next year and a lot of unresolved issues. He has our best wishes for a successful year as the 140th President of KMA. This is actually a job for *two* people — the President *and* his wife. KMA's "First Lady" is a very important ambassador for Kentucky medicine wherever she goes. Sue and I wish Preston and Lucille strength, good health, and joy in the task ahead. That famous philosopher Yogi Berra once said, "Most of the future is still ahead of us." Let us face our future as it unfolds with "Pride in Medicine."

Nelson B. Rue, MD
KMA President

Reference

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References

1. USP DI Update, September/October 1988, p 120.
2. Br J Clin Pharmacol 1985;20:710-713.
3. Data on file, Lilly Research Laboratories.
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5. Am J Gastroenterol 1989;84:769-774.

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Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose-related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high-dose males as compared with placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high-dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement as compared with concurrent controls and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery are not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, mouse lymphoma assay, chromosome aberration tests, and a micronucleus test.

In a two-generation, perinatal and postnatal fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose and in Dutch Belted rabbits at doses up to 55 times the human dose revealed no evidence of impaired fertility or teratogenic effect; but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus, and at 50 mg/kg, it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Studies in lactating women have shown that 0.1% of an oral dose is secreted in human milk in proportion to plasma concentrations. Because of growth depression in pups reared by treated lactating rats, a decision should be made whether to discontinue nursing or the drug, taking into account the importance of the drug to the mother.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Healing rates in elderly patients were similar to those in younger age groups as were the rates of adverse events and laboratory test abnormalities. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of varying durations included almost 5,000 patients. Among the more common adverse events in domestic placebo-controlled trials of over 1,900 nizatidine patients and over 1,300 on placebo, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common with nizatidine. It was not possible to determine whether a variety of less common events was due to the drug.

Hepatic—Hepatocellular injury (elevated liver enzyme tests or alkaline phosphatase) possibly or probably related to nizatidine occurred in some patients. In some cases, there was marked elevation (>500 IU/L) in SGOT or SGPT and, in a single instance, SGPT was >2,000 IU/L. The incidence of elevated liver enzymes overall and elevations of up to three times the upper limit of normal, however, did not significantly differ from that in placebo patients. Hepatitis and jaundice have been reported. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

CNS—Rare cases of reversible mental confusion have been reported.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to nizatidine. Impotence and decreased libido were reported with equal frequency by patients on nizatidine and those on placebo. Gynecomastia has been reported rarely.

Hematologic—Fatal thrombocytopenia was reported in a patient treated with nizatidine and another H_2-receptor antagonist. This patient had previously experienced thrombocytopenia while taking other drugs. Rare cases of thrombocytopenic purpura have been reported.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine- than in placebo-treated patients. Rash and exfoliative dermatitis were also reported.

Hypersensitivity—As with other H_2-receptor antagonists, rare cases of anaphylaxis following nizatidine administration have been reported. Because cross-sensitivity among this class has been observed, H_2-receptor antagonists should not be administered to those with a history of hypersensitivity to these agents. Rare episodes of hypersensitivity reactions (eg, bronchospasm, laryngeal edema, rash, and eosinophilia) have been reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported. Eosinophilia, fever, and nausea related to nizatidine have been reported.

Overdosage: Overdoses of Axid have been reported rarely. If overdosage occurs, activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

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Delegates Report 1990 Annual Meeting of the AMA House of Delegates

A report by Alternate Delegate Donald J. Swikert, MD

The American Medical Association House of Delegates met in Chicago, June 24-28, 1990. The volume of business was the heaviest in history with 295 resolutions and 110 reports reviewed and considered. A broad range of issues was considered in socio-economics, science, ethics, and governance of the Association.

Prior to the meeting, on June 19, the Board of Trustees named James S. Todd, MD, as the Executive Vice President. Dr Todd, 58, had been acting Executive Vice President since February 9, when James S. Sammons, MD, who served the Association as Executive Vice President for 15 years, stepped down in the wake of criticism over financial transactions. Dr Todd indicated that his top priority was to get the US health system reorganized along the lines of Health Access America.

During the 139th annual meeting, C. John Tupper, MD, was installed as the 145th President of the American Medical Association. Dr Tupper is an internist from Davis, California.

John J. Ring, MD, a family physician from Illinois, was elected as the new President-Elect. Dr Ring has served as Chairman of the Board for the last two years.

Reelected to the Board of Trustees were Joseph T. Painter, MD, an internist from Texas, and Robert E. McAfee, MD, from Maine. In addition, Palma E. Formica, MD, a family physician from New Jersey; Thomas R. Reardon, MD, a family physician from Oregon; and P. John Seward, MD, a family physician from Illinois, were elected for the first time to the Board. Michael D. Hagen, MD, a family physician from Lexington, Kentucky, ran unsuccessfully for a seat on the Council of Scientific Affairs. His candidacy impressed many in the House. Judy Linger, a medical student from Kentucky, was reelected to the AMA Medical Student Section Governing Council and was elected as chairperson. We congratulate Judy on her success and extend her our best wishes on a most successful and productive term.

The volume of business was the heaviest in history with 295 resolutions and 110 reports reviewed and considered.

During the opening session of the House of Delegates, Lt Governor Brereton C. Jones received the American Medical Association's Citation of a Layman for Distinguished Service Award. This award is presented to individuals not of the medical profession who help achieve the ideals of medicine by cooperation or aid in the achievement of medical science, medical education, or medical care. The Lt Governor's remarks were enthusiastically received by the entire assembly. He complimented the 2291 physicians who participate in the KMA Physicians Care Program. He indicated that the commitment of those physicians resulted in an estimated 111,240 physician encounters. Without their help, he acknowledged, this award would not have been possible.

Health Access America

Health Access America, a plan to integrate AMA policies into one cohesive approach to build on the strengths of the United States health care system and address its significant weaknesses, received much discussion. It puts AMA in the public policy debate regarding health care system reform. It speaks to insuring our people, to cutting bureaucratic waste, to assuring quality, and to seeking solutions to the liability crisis.

Health Access America would increase access to health care by enacting major Medicaid reform to assure that, at the very least, all those at 100% of poverty are covered. This could be accomplished by setting uniform eligibility standards adjusted to local economic conditions and by developing a minimum package of benefits that will be the same in every state. Reimbursement at Medicare rates would help to improve access. Access to care would be increased by extending employer coverage to workers and their families, while providing tax credits to assure that small businesses can implement these provisions without undue financial burden; by creating state-level risk pools; and by reforming the Medicare program so that every American would be assured of benefits at retirement without concern that the system will be bankrupt. Other elements include reducing the

cost of defensive medicine, including lowering the cost of liability insurance through tort reform and promoting an administrative claims settlement plan; intensifying the AMA's oversight of physician ethics; continuing efforts to eliminate the hassle factor; and continuing to develop practice parameters.

The House of Delegates called upon the AMA to encourage all county, state, and specialty societies to endorse and support the elements of the AMA's Health Access America program, and that such efforts should involve the active promotion and dissemination of this program at the local grass roots level.

Legislative Initiatives

The American Medical Association has had major impact in the "Physician Regulation Relief Amendment of 1990." This bill has been introduced as H.R. 4475, by Representative J. Roy Rowland, MD (D-GA), and a similar bill introduced in the Senate, S. 2591, introduced by Senator Max Baucus (D-MT). These bills would provide substantial relief from the arbitrary regulatory "hassles" imposed on physicians by HCFA. These two bills contain five major reforms.

It is important to write your Senator and Representative and ask for their support of this anti-hassle legislation.

The first provision would require HCFA and Medicare carriers to release numerical frequency limits, known as Medicare review screen parameters, to physicians.

The second provision would allow doctors to continue a time honored practice of patient coverage arrangements when the regular physician is not available.

The third provision would prohibit Medicare carriers from charging physicians for information that is needed to comply with Medicare statutory and regulatory requirements.

Health Access America would increase access to health care by enacting major Medicaid reform to assure that, at the very least, all those at 100% of poverty are covered.

A fourth provision would allow medical societies to file Medicare reconsideration and appeal requests on behalf of their member physicians.

The fifth provision would create a congressionally mandated Practicing Physician Advisory Council to provide HCFA with recommendations on implementing Medicare statutory and regulatory requirements.

It is important to write your Senator and Representative and ask for their support of this anti-hassle legislation.

Two bills have been introduced to restore the deductibility interest on student loans which were severely limited by Congress in 1987. They are H.R. 747, introduced by Representative Richard Schulze (R-PA), and S. 656, introduced by Senator Charles Grassley (R-IA). Each bill would extend interest deductibility beyond current law. Presently, H.R. 747 is cosponsored by Representative Bunning (R-KY), Representative Hopkins (R-KY), Representative Hubbard (D-KY), Representative Mazzoli (D-KY), Representative Perkins (D-KY), and Representative Rodgers (R-KY). Senate Bill S. 656 is presently not cosponsored by any Kentucky Senators. It is important for physicians to either ask for the cosponsorship of these bills by their Representative or Senator or to thank those that are already cosponsors for their support.

Another legislative initiative involves the 1991 balanced billing limit: "The 125% rule." As a last-minute insertion into the final reconciliation bill in 1989, Congress imposed balance billing limits of 125% of the local prevailing or a physician's 1990 Maximum Allowable Actual Charges (MAAC), whichever is less, on all services starting January 1, 1991. These limits take effect one year prior to the implementation of the Resource-Based Relative Value Scale (RBRVS). The 1991 balanced billing limits would significantly lower revenues for medical services actually scheduled for increases in 1992 under the RBRVS and would, in addition, immediately place the burden of anticipated RBRVS decreases on physicians who were promised by Congress a gradual 5-year phase-in of RBRVS cuts. The AMA is proposing that Congress adopt a 1-year, across-the-board delay of the balanced billing limits to coincide with the phase-in of the RBRVS. It is critical that all Senators and Representatives hear from their physician constituents and state medical societies regarding the need for a legislative solution to this potentially devastating problem. We encourage physicians to urge their Senator and Representative to support a one-year, across-the-board, budget neutral delay of the 1991 balanced billing limits.

The last legislative initiative involves the proposed regulations implementing the final portions of the Clinical Laboratory Improvement Amendments (CLIA-88) which were formally published in the *Federal Register* on Monday, May 21, 1990, with a

90-day comment period. The regulations set requirements for laboratory tests based on the complexity of the test and the risk factors related to erroneous test results. The proposed regulations are site-neutral and would establish three tiers: waived tests with no regulation (other than registration of the site); level I for more complex tests; and level II for the most complex tests and regulation. The fee schedule for obtaining a certificate and the process for application will be established through subsequent proposed regulations. Additional regulations also will be proposed to establish the standards required for private accreditation agencies to be approved by the Secretary of the Department of Health and Human Services. The American Medical Association has already been very active in seeking modifications in these proposed regulations. The House of Delegates passed resolutions calling for intensified efforts to seek appropriate modifications to the proposed rules; to communicate to Congress and to the Health Care Financing Administration the positive contribution of physician office laboratory testing to high quality, cost-effective care; and to continue to work with the Congress, the Health Care Financing Administration, the Commission on Laboratory Assessment, and other medical and laboratory groups to make regulation of physicians' office laboratories reasonable.

These bills would provide substantial relief from the arbitrary regulatory "hassles" imposed on physicians by HCFA. These two bills contain five major reforms.

We encourage physicians to urge their Senator and Representative to support a 1-year, across-the-board, budget neutral delay of the 1991 balanced billing limits.

Another legislative issue involves the proposed cytology regulations as related to the Clinical Laboratory Improvement Act of 1988. The AMA expressed its opposition to these proposals in May. The House of Delegates passed the resolutions to urge Congress to modify the final rule on cytology proficiency testing because it represents relicensure/recertification of a segment of a medical specialty practice by Federal Government fiat without due process; and to study the effect of the final regulations for clinical laboratories on the cost, decreased availability, and willingness of patients to submit to pap smears.

IRS pension regulations were discussed at length. The IRS interpretation of section 1.414 (M) and (N) has adversely affected the pension plans of affiliated service organizations and leased employees. The House resolved "that the AMA use all appropriate resources, including legal action if necessary, to seek changes in the proposed Internal Revenue Service regulations regarding pension and profit sharing plans; seek a delay in the effective date of the proposed regulations; and if such regulations are adopted, to ensure that they only be applied prospectively."

The issue of Medicare medical office screens was considered at length. Presently HCFA has directed Medicare carriers to use medical office screens in retrospective review of medical office practice patterns. The House passed the following resolution to address this issue:

> "that the American Medical Association take the following actions: 1. seek specific clarification from the Health Care Financing Administration on the process, procedures, and criteria of physician office post payment review and recoupment; 2. lobby for full due process protection for carrier post payment review and recoupment situations; 3. oppose the concept and application of extrapolation; 4. oppose arbitrary, erratic, or inappropriate components of post payment review and recoupment; and 5. seek appropriate relief to achieve equitable treatment of physicians in office post payment review and recoupment situations."

There were many other issues considered and deliberated upon during the 4-day session. The Kentucky Delegation will try to cover highlights of some of these issues in future issues of the KMA *Journal.*

The Role of Functional Dorsal Rhizotomy for the Treatment of Children With Spastic Cerebral Palsy

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Functional dorsal rhizotomy is now a frequently used procedure in the treatment of spastic cerebral palsy. Appropriate candidate selection is imperative for good results to be achieved. The pathophysiology of spasticity and candidate selection criteria are discussed.

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Historical Review

Rhizotomy, derived from the Greek words rhizo and tome, refers to the sectioning of intraspinal nerve roots/rootlets. The procedure has been used as a treatment for spasticity since the early 1900s, when Foerster first described the results of dorsal (sensory) root section.[1] Although Foerster's results varied from good to excellent, the complications associated with whole root section (hypotonia, positional ataxia, sensory loss, trophic skin changes) hindered the acceptance of the procedure. In 1967, Gross repopularized the procedure by advocating the concept of partial sensory root section wherein only 80% of the dorsal roots were sectioned. This technique resulted in a considerable reduction in side effects but substantial recurrence rates were observed.[2] Sindou (1972) reported an improvement in long term results by selectively sectioning dorsal root fibers anatomically at the dorsal root entry zone.[3, 4, 5] In 1978, with the availability of intraoperative electromyography (EMG), Fasano continued the advancement of rhizotomy techniques by selectively cutting nerve rootlets whose intraoperative electrophysiological stimulation responses implicated them as playing a major role in contributing to the patient's spasticity. The utilization of intraoperative EMG recordings to select out and section specific nerve fibers is referred to as functional (selective) dorsal rhizotomy (FDR).[6, 7, 8] Through Fasano's work and later Peacock's (1981),[9, 10] FDR has become an established technique for the treatment of spasticity in children with cerebral palsy (CP).

Physiology

To understand how FDR works in providing long term spastic relief requires knowledge of the basic mechanisms underlying spasticity and its clinical differentiation from other motor system disorders not responsive to this treatment in patients with CP. Although the definition of spasticity is varied in the medical and research literature, it is best clinically defined as a motor disorder characterized by a *velocity* dependent hyperactivity of the tonic stretch reflexes, ie, muscle tone.[11] The increase in muscle tone is proportional to the velocity of the stretch. Associated findings may also include hyperactivity of the deep tendon reflexes, clasp-knife responses and clonus.[11-14] Spasticity represents only one component of an upper motor neuron lesion and it may represent only one facet of the clinical abnormalities of patients having complex motor system disorders, as are often present in children with cerebral palsy.

Physiologically, spasticity is the result of a deficit in the interneuronal integrative control at the segmental spinal cord level and it is presumed directly related to changes incurred through a loss of descending control. Although the underlying pathogenesis of spasticity remains poorly understood (and may differ between patients),[14] the key feature is that the final common pathway, alpha motoneuron discharge, is hyperactivated either by a decrease in inhibitory influences and/or a relative increase in excitatory post-synaptic potentials resulting in an increase in muscle tone.[13-16] Several hypotheses exist to explain this relative hyperactivity.[6, 8, 12-17] Muscle spindle activity (1A afferent sensory input) does not appear to be hypersensitive or hyperactive. Rather there exists a failure to properly control, through loss of interneuron inhibition, 1A afferent (and other sensory) input at the spinal cord level.[7, 8, 13] FDR serves to decrease the amount of abnormally controlled sensory input to thus decrease motor tone.

Concerning descending control, in patients with CP, it is essential to realize that direct damage to primary motor or pre-motor cortex, although producing a severe motor loss, will not

Table 1. Clinical Classificatian af Cerebral Palsy

A.	Spastic
	diplegia
	hemiplegia
	quadriplegia
B.	Ataxic
	pure
	spastic-ataxia
C.	Dystonic
	athetoid
	clareifarm
	mixed
D.	Tremorous
E.	Rigid
F.	Mixed

alone produce spasticity.[18] Rather, it is the injury to the fine cortical spinal fibers arising diffusely from the cerebral cortex or direct injury to the supplemental motor area which are responsible for increasing muscle tone. It is the injury to these fibers (periventricular leukomalacia) with the relative sparing of the basal ganglia and fibers from the primary motor cortex that make FDR an attractive procedure for the treatment of spasticity in CP children (ie, preserved motor function in the presence of underlying spasticity).

Patient Selection Criteria

The majority of pediatric patients currently assessed as potential candidates for FDR have been previously diagnosed with CP. However, CP is a heterogenous term that is attached to all children suffering a cerebral insult, regardless of cause, during the neonatal period. Thus, CP serves to group together widely disparate neurological conditions which have in common their early age of onset, being nonprogressive anatomically and having shared management problems. The term broadly describe complex and often multifaceted abnormalities of the central nervous system characterized by a persistent but *not unchanging* disorder of their motor control.

CP can be classified according to its etiology but more commonly it is classified according to the predominate motor abnormality present as the child matures (Table 1).[19] Several associated medical problems including seizures, learning disabilities, IQ deficits, visual, auditory, and speech difficulties often coexist. Mixed forms are not uncommon.

As a result of the diverse presentations of children with cerebral palsy, a careful selection of candidates must be made to identify those who will clearly benefit from FDR.[8, 10] Clinically it is not only important to identify the presence and degree of spasticity but also the coexistence of other motor and osteotendinous abnormalities (rigidity, postural dystonia, and contractures) that will not respond to this form of treatment.[7, 10, 12]

Different from spasticity, rigidity is characterized by a *nonvelocity* dependent increase in muscle tone that is constant throughout the range of motion. Both agonistic and antagonistic muscle groups are involved. The presence of rigidity implies lesions involving the substantia nigra or the basal ganglia which would not be effectively treated by FDR. On clinical grounds, however, it may be extremely difficult to differentiate severe spasticity from rigidity. In such cases MR imaging of the brain is often necessary to anatomically locate the cerebral lesions (periventricular white matter, basal ganglia) as part of the selective process.[20]

Postural dystonic movements associated with an increase in muscle tone are easier to recognize and differentiate from spasticity. They represent diffuse uncoordinated involuntary movements with widespread muscular contraction in the presence of normal deep tendon reflexes. Their presence implies injury to the basal ganglia, a condition again not effected by FDR.

Although chronic spasticity can cause the development of osteotendinous changes, ie, joint contractions, muscle fibrosis,[21] when fully developed these are not reversible by simple tone reduction procedures. FDR, however, may be the first step in *selected* patients in the effective management of these problems.

The clinical presentation of children with CP, as a result, often involves a mixture of motor and osteotendinous abnormalities. A careful selection of patients must be made in order to identify those candidates that will clearly benefit.[8, 10] Table 2 summarizes factors important to candidate selection. The children in Group 1 represent potential ambulators whose major motor abnormality is spastic diplegia. Emphasis is placed on a strong commitment by the family and patient to an intensive postoperative physical therapy program so as to derive the maximum potential benefit of the procedure. The presence of contractures and previous lower limb operations are discussed, as they will influence the child's ability to improve muscle strength and assume a more normal gait

following an FDR. Patients with moderate to severe underlying motor weakness are approached cautiously, as a decrease in muscle tone may markedly impair their current ambulatory skills which are dependent on their muscle hypertonicity. Strengthening of postural muscle groups should be done prior to FDR in patients with moderate to severe postural hypotonia and trunk weakness.

A second group of patients (Group 2) are represented by children who have remained moderately to severely spastic despite previous medical and/or surgical management, so that basic day to day nursing management is a major challenge. These children are not potential ambulators, and thus intelligence, commitment to a postoperative physiotherapy program, and previous limb surgery are not primary concerns. These children are spastic quadriplegics and usually require special bracing to maintain their bodies in position. In addition to being able to provide *partial* spasticity and mass reflex relief in a number of patients, a tone reduction procedure (FDR) may be needed prior to obtaining successful hip, knee, or ankle surgery to treat concomitant osteotendinous changes.

Many children with CP, however, will not ideally fit these criteria and may have one or several relative but not absolute contraindications to surgery (Table 3). Individual and multidiscipline assessments of these children are required. In common, however, is their underlying spasticity for which the performance of a rhizotomy to reduce muscle tone may be an important part of their overall management.

Several children are not candidates (Table 4). These children have major problems, other than spasticity, with regards to motor control or already have multiple joint contractures. Prior multiple limb procedures and mental retardation would also provide unrealistic expectations if the goal is toward improved ambulation. Very severe spastic quadriplegics are another group that must be given careful thought. Usually in these patients all rootlets stimulated are abnormal, and partial rhizotomies (60% to 70%) may maintain only minimal long term spasticity relief.

Due to the wide spectrum of clinical manifestations present in children with CP, it is important that a team approach be employed in selecting good candidates for FDR. Members of this team should include a physical therapist, occupational therapist, social worker, pediatrician, neurophysiologist, orthopaedic surgeon and a surgical neurologist. Psychological assessments may be required in selective patients.

Table 2. Ideol Condidates

A. Group 1 — Potential ambulators
- born premoturely
- predominontly spastic diplegic
- oges 2-10
- IQ > 80
- progressive motor development history
- commitment to post-op physiotherapy
- fomily support
- obsence of controctures
- minimal/no prior lower extremity surgery
- minimol/no osteotendinous chonges
- good underlying motor strength/potential
- obsence of posturol hypotonio

B. Group 2 — Nursing Management
- moderate — severe sposticity (diplegic, quodriplegic)
- foilure of response to medical/surgicol manogement
- future lower limb surgeries anticipoted due to development of controctures ond progressive joint subluxotions

Table 3. Potentiol Condidotes
- limited extremity surgery
- limited controctures
- limited osteotendinous changes
- oge > 10
- IQ < 80
- moderote to severe muscle wosting
- etiology of CP reloted to meningitis, congenitol infection, hydrocepholus, head troumo

Table 4. Contraindications
- severe scoliosis - major non-spostic motor disorders (athetosis, rigidity, dystonio, otoxio)
- multiple prior extremity surgery (except Group 2)
- mentally retorded (except Group 2)
- multiple controctures

Table 5. Potential Surgical Complications

- kyphosis
- wound infection/meningitis
- CSF leak
- motor paralysis
- transient/permanent sensory loss
- bladder/bowel dysfunction
- equinus (valgus/varus) foot positioning
- transient muscle weakness/hypotonia
- anesthetic risk

Table 6. Supra and Infra Segmental Changes

- improved speech patterns
- improved oral-pharyngeal control
- decrease in mass reflexes
- decrease spasticity in upper limbs
- improved fine motor control
- improved seizure control
- improved bladder control
- increased postural tone
- positive personality changes
- increased agility and freedom of movement

Peri-operative Management

Preoperative electrophysiological studies[22, 23] and a preoperative video of the child's ambulation and motor skills are performed in addition to detailed clinical and historical documentation by members of the examining team to provide essential baselines for follow-up studies.

Intraoperatively, electrodiagnostic nerve root and rootlet stimulation are recorded from multiple and bilateral skin or needle EMG electrodes to identify abnormal rootlets participating in the spasticity circuit. A clinical observation of the type and location of associated muscular contractions are also made. Important criteria in determining abnormal rootlet function are muscular contraction that is either electrically or clinically diffuse or involving contralateral muscle groups following high frequency stimulation; that which is sustained or present following stimulus release (after discharge); or that which has a low threshold for contraction.[8, 10, 23, 24, 25, 26] Spinal rootlets from the L2 to S1 (occasionally S2) roots bilaterally are stimulated. The percentage of sensory rootlet sections may vary from zero to 80% per root and 25% to 65% overall.

Postoperatively, physical therapy is initiated on the third postoperative day. Depending on the child's individual needs, an outpatient physical therapy program is designed at the time the child leaves the hospital (fifth to seventh postoperative day). Potential ambulators will require a minimum of 2 to 6 months of intensive physical therapy (3 to 5 times per week) with an emphasis on muscle strengthening and gait retraining following the procedure.

Complications

To date, complications have been infrequent and are of a transient nature (Table 5).[7, 10] FDR however does have the potential to produce serious neurological and life threatening risks (motor paralysis and meningitis). Fortunately these are very rare. More commonly, transient hypotonia, transient sensory disturbance, or a transient disturbance in bladder function may be noted. Postoperative kyphosis remains a potential long term complication, however its risk factor is quite small if limited laminectomies are performed.[29]

Results

Current follow-up studies (10 years) have shown long term and sustained reductions in muscle tone in over 90% of the selected candidates (Group 1). Recurrence rates have been less than 5% and occur primarily in those children operated on who have had other motor disorders. In both Fasano's[7, 8] and Peacock's[9, 10, 30] studies over 95% of selected patients (Group 1) showed significant improvement in postural balance and walking dynamics. Unexpected findings at supra and infrasegmental levels have also been noted (Table 6). The physiology underlying these results are not clearly understood but underscore the supra and infrasegmental spinal cord distribution of afferent segmental fibers.

At the time of this writing, 13 patients had undergone an FDR at Kosair-Childrens Hospital (Louisville, KY). They have been followed a minimum of 3 months post surgery. Four of six Group 2 patients have shown a substantial reduction in motor tone (Ashworth scale) and mass reflex spasms and have achieved their goals in obtaining better nursing management and care. Two patients with severe spasticity had partial recurrences of their spasticity within 2 months following surgery, which may be related to the percentage of nerve rootlets sectioned. One child is still more easily managed, has improved upper

extremity control, and has had positive but subjective personality changes. Five of these patients have had suprasegmental functional improvement.

All seven of the Group 1 (Table 2) patients have experienced significant decreases in muscle tone and have all made very significant advances with regards to ambulation, freedom of movement, and muscle strength as compared to their preoperative assessments. Several have had improvement in their speech, upper extremity coordination, and postural control.

Summary

FDR is a new and current approach for the treatment of spasticity in children with CP. Although the long term results need further documentation, extended follow-ups have been encouraging.[28] In properly selected cases, results have been very good and at times remarkable and are associated with a minimum complication risk. FDR should be considered in the management plan of all children with spastic cerebral palsy.

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Outpatient Left Heart and Coronary Arteriography

The Current Practice at the University of Louisville School of Medicine

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Introduction

Radiographic imaging of the coronary arteries was predicated on the discovery of x-rays by William Roentgen in December 1895.[1] Significant technical advancements have occurred over the last 100 years and have extended the technique from the diagnostic to therapeutic arena. It is estimated that in 1986 there were 775,000 diagnostic cardiac catheterizations performed and an additional 59,000 attempts of percutaneous transluminal coronary angioplasty.[2,3]

The purpose of this review is to summarize the development of diagnostic coronary arteriography and to familiarize the reader with the current practice of this technique at the University of Louisville School of Medicine in an outpatient population.

Historical Review

The reader is referred to comprehensive reviews of the history of cardiac catheterization described by J. Willis Hurst and W. Bruce Frye.[4,5] A highlight of some of the events enables one to appreciate the recent technological achievements over the last several years.

Werner Forssmann, in 1929, was the first person to catheterize himself utilizing a urethral catheter from the left brachial vein into the right atrium.[6] Additional contributions by Forssmann, Cournand, and Richards were recognized in 1956 when they received the Nobel Prize in Medicine.[7,8]

Left heart catheterization was initially reported by Zimmerman in 1956 in a patient with aortic regurgitation.[9] This technique provided faint visualization of the proximal segments of the coronary arteries, but was insufficient to define exact anatomical details. Mason Sones, in an attempt to provide additional angiographic definition, described semiselective coronary arteriography where he purposely directed contrast media into one of the sinuses of Valsalva. He later developed selective coronary arteriography with a tapered tipped catheter which allowed selective entry into the coronary ostia but avoided complete obstruction of the coronary artery. The results of the initial 1,000 patients who underwent this technique was published in 1962, and provided the cornerstone from which more widespread application was based.[10]

Inpatient Cardiac Catheterization

Cardiac catheterization was initially applied in patients who underwent extensive preprocedural, in hospital evaluation and postprocedural observation. With the advancement of equipment and procedural skills the hospital stay has gradually decreased, yet still is considered to require at least 1 night in hospital.

The frequency of complications inherent to the procedure in the inpatient population are listed in Table 1. In this accumulated series of over 100,000 patients, death occurred in 0.3% and total complications occurred in 2.8%.[11-14]

Outpatient Cardiac Catheterization

Table 2 lists the complications of 10 series with an accumulated experience of over 10,000 patients. Death or myocardial infarction each occurred in 0.1%. A vascular event requiring hospitalization was reported in 1.8% and total complications including central nervous system and arrhythmia events were noted in 2.4%.

A comparison of complications in reported series of inpatients and outpatients is seen in Table 3. High statistically significant differences were found in all categories: death, myocardial infarction, vascular events, and arrhythmias. There was no difference in the occurrence of central nervous system events. This comparison does reveal that with rigid preprocedural selective criteria, cardiac catheterization can be safely performed with a minimal incidence of serious complications in an outpatient population.

Vascular Complications in the Outpatient Population

Peripheral vascular complications including arterial thrombosis, laceration, embolization, and hematoma formation requiring evacuation ac-

Table 1. Complicotions From Inpotient Coronary Arteriogrophy

1st AUTHOR[ref] (yeor)	N	Technique	F.	Deoth %	MI %	Vasculor %	CNS %	Arrhythmio %	Totol %
Adams[11] 1973	46,904	F 49% B 51%	—	0.5	0.6	1.6	0.2	1.3	4.2
Bourassa[12] 1976	5,250	F 100%	—	0.2	0.1	0.9	0.1	1.0	2.3
Davis[13] 1979	7,553	F 84% B 16%	—	0.2	0.3	0.7	0	0.6	1.7
Kennedy[14] 1982	41,204	F 56% B 44%	—	0.1	0.1	0.6	0.1	0.6	1.4
TOTAL	100,911	—	—	0.3	0.3	1.1	0.2	1.0	2.8

Abbreviations: F = femorol; B = brochiol; MI = myocardial infarction; CNS = centrol nervous system

Table 2. Complications From Outpotient Coronary Arteriogrophy

1st AUTHOR[ref] (year)	N	Technique	F.	Deoth %	MI %	Vosculor %	CNS %	Arrhythmio %	Totol %
Baird[15] 1980	620	B 100%	—	0.2	0.2	0.2	—	0.3	1.0
Mohrer[16] 1981	308	F 95% B 5%	—	0.3	1.0	0.7	0.3	—	1.9
Diethrich[17] 1981	254	B 100%	—	0	0	—	0	0.8	0.8
Oehlert[18] 1981	100	F 94% B 6%	—	0	0	0	0	1.0	1.0
Fierens[19] 1984	5,107	B 100%	—	0	0	2.5	0	0.1	2.6
Klinke[20] 1985	3,071	F 98% B 2%	—	0.1	0.1	0.4	0.1	0.4	1.1
Mohrer[21] 1987	2,207	F 97% B 3%	7	0.1	0.1	0.2	0.1	0.6	0.8
Block[22] 1988	192	F 98% B 2%	7,8	0	1.6	14.1	0	—	15.7
Pink[23] 1989	1,000	F 99.6% B 0.4%	8	0	0.2	1.7	0.4	0.4	2.7
Multicenter Trial[24] 1989	287	F 100%	5	0	0	0	0.4	0.7	1.0
TOTAL	13,146	—	—	0.1	0.1	1.5	0.1	0.3	2.1

Abbreviotions as in Toble 1.

Table 3. Coronory Angiogrophy Complicotions

	Deoth %	MI %	Vasculor %	CNS %	Arrythmio %	Total %
Inpotient	0.3	0.3	1.1	0.2	1.0	2.8
Outpatient	0.1	0.1	1.5	0.1	0.3	2.1
p Value	<0.0001	<0.0001	<0.0001	NS	<0.0001	<0.0001

Abbreviotions os in Toble 1; NS = not significont ($p>0.05$)

Table 4. Cardiac Catherization — Complications Based on Catheter Size

1st AUTHOR[ref] (year)	N	Technique	F.	Death %	MI %	Vascular %	CNS %	Arrhythmia %	TOTAL %
Mahrer[21] 1987	2,207	F 97% B 3%	7	0.1	0.1	0.2	0.1	0.6	0.8
Pink[23] 1989	1,000	F 99.6% B 0.4%	8	0	0.2	1.7	0.4	0.4	2.7
Multicenter Trial[24] 1989	287	F 100%	5	0	0	0	0.4	0.7	1.1
p Value				NS	NS	<0.0001	NS	NS	<0.0001

Abbreviations as in Table 1
NS = not significant (p>0.05)

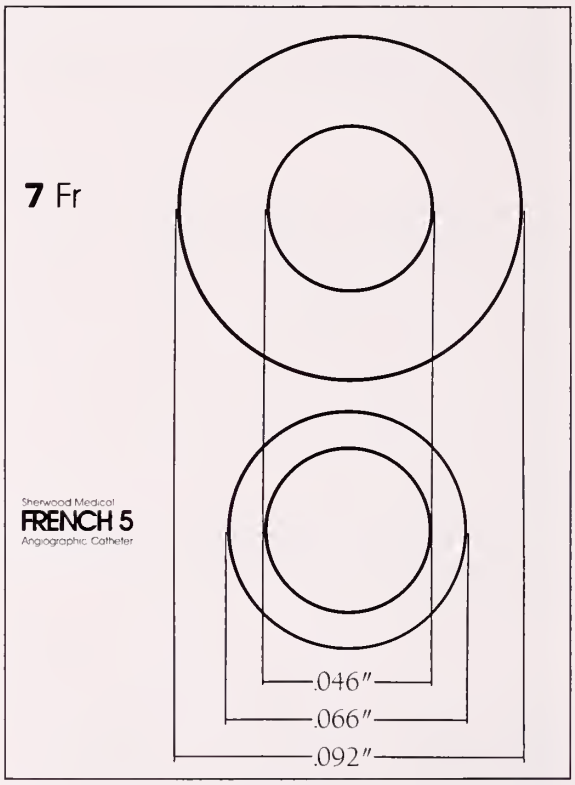

Fig 1 — Comparison of internal and external dimension of French 5 catheter (Sherwood Medical, St. Louis, MO) and larger 7 French catheter. The internal diameter is the same, with a significant decrease in external caliber. (Figure courtesy of Sherwood Medical, St. Louis, MO).

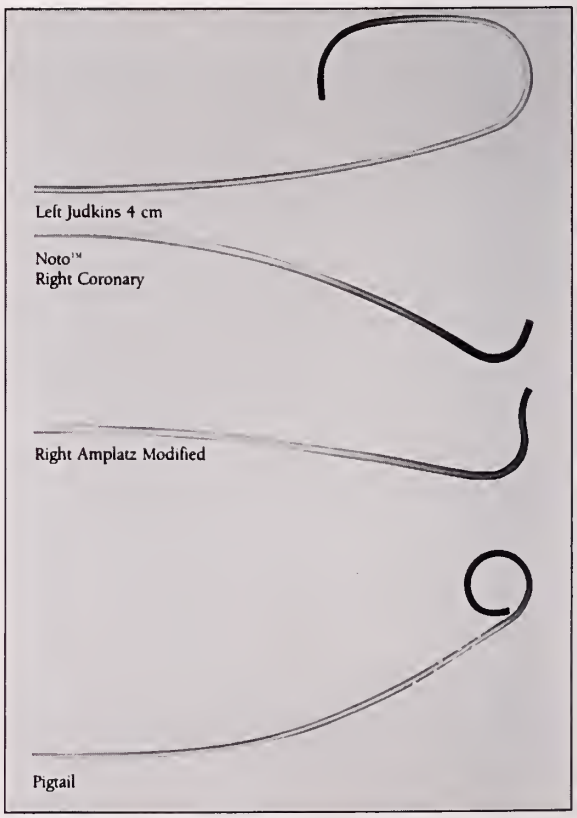

Fig 2 — Representative configurations of French 5 diagnostic catheters (Sherwood Medical, St. Louis, MO). (Figure courtesy of Sherwood Medical, St. Louis, MO).

count for a significant amount of procedural morbidity in the inpatient or outpatient populations.

Table 4 lists the complications in outpatient series based on catheter size utilized during the cardiac catheterization procedure. This table lists the three series in which catheter size was identified.

Statistical analysis of complications based on catheter size revealed a significantly smaller incidence of vascular complications ($p < 0.0001$) with the use of 5 French (F) (0.46″ inner and 0.66″ outer diameter) catheters.

Current Technology — The 5 French Catheter

The large bore French™ 5 diagnostic catheters (Sherwood Medical, St. Louis, MO) are 100 cm in length, typical of currently available larger models. The shaft is constructed of Urelon™, a rigid copolymer of 98.5% nylon and 1.5% urethane bonded together in a co-extruded shaft. There is a gradual transition zone 2.5 cm from the tip which is increasing composed of urethane. The distal tip is tapered and consists totally of soft, pliable urethane, allowing for safe cannulation and selective injection of the coronary arteries. The proximal rectangular end facilitates connection to the manifold or injector.

The internal dimension of the catheter in comparison to the currently available 7F system is seen in Fig 1. The internal dimension of the 5F catheter is 0.46 in. This internal dimension resembles the size of the 7F catheter. The external dimension of the 5F catheter is 0.66 in.

Currently, only preformed catheters are available. For cannulation of the left coronary artery, a left Judkin's system is utilized and is available in 3.5F, 4.0F, 5.0F and 6.0F sizes. The right coronary artery is engaged with the Noto™ right coronary catheter. This catheter is preformed, selective, and does not require "torqueing" as is needed with right Judkin's systems. Two catheters are available for ventriculography: a ventricular catheter or pigtail. For selective injection of an anteriorly placed right coronary artery or a saphenous vein graft, a modified Amplatz catheter is available. Representative catheter shapes are seen in Fig 2.

Current Experience at the University of Louisville School of Medicine

The Cardiovascular Division at the University of Louisville was involved in the Multicenter Trial of early ambulation with 5F diagnostic cardiac catheterization in conjunction with Cedar-Sinai Medical Center, Los Angeles, CA; Duke University Medical Center, Durham, NC; Mt. Sinai Medical Center, New York, NY; and St. Louis University Hospital, St. Louis, MO. In this series, 91% of the patients were ambulated at a mean of 1.8 hrs post procedure. Eighteen patients developed a small hematoma (< 5 cm) and no patient required either admission, blood transfusion, or surgical intervention for management of the hematoma. Correlates of the development of a hematoma included the concurrent use of heparin and aspirin as well as compression time < 10 min. Only 1% of patients needed 7 or 8F catheter for suboptimal 5F coronary angiography, and 92% of the patients had a complete study with available 5F catheters.[24]

Outpatient Catheterization Protocol

The protocol utilized in selecting patients for the outpatient procedure is identified in Table 5. It is important to note that rigid selection criteria are applied. Risk stratification is based on 5 factors: the presence of significant (New York Heart Association Class III or IV) congestive heart failure; the presence of unstable angina pectoris; recent myocardial infarction; significant noncoronary heart disease; or severe non-cardiac disease. An additional important factor is the presence of a friend or family member to help provide lodging and/or transportation for the patient.

The catheterization protocol utilized at the University of Louisville School of Medicine is identified in Table 6. The history, physical, and laboratory evaluation is performed 2-7 days before the catheterization is performed. The precatheterization evaluation is routinely done by the refer-

Table 5. Precatheterization Protocol

- Significant pretest probability of significant coronary arterial obstruction
- Risk stratification
- NYHA Class III or IV congestive heart failure
- unstable angina pectoris
- recent myocardial infarction
- significant non-coronary heart disease
- severe non-cardiac disease
- Presence of friend or family for transportation and/or lodging

Abbreviations: NYHA = New York Heart Association

Table 6. Catheterization Protocol

- History, physical and laboratory evaluation performed 2-7 days before catheterization by referring physician
- Admitted to hospital on day of procedure
- Catheterization scheduled for morning
- Percutaneous transfemoral technique with 5F catheters, without routine heparinization or placement of arterial sheaths
- Manual compression until hemostasis achieved
- Pressure dressing applied

Table 7. Post-Catheterization Protocol

- Supine bedrest for 2 hours
- Vital signs and groin complications checked every 15 to 30 minutes
- At completion of bedrest, ambulation for 30 minutes
- Discharged home 3 hours after completion of procedure

Table 8. Benefits of Outpatient Cardiac Catheterization

Facility utilization Personnel efficiency	Cost containment
Patient comfort Less employment time loss	Patient satisfaction

ring physician and the results forwarded with the patient. The patient is admitted to the hospital on the day of the procedure to our out patient facility. Cardiac catheterization is scheduled for the morning and performed by the percutaneous transfemoral technique with 5F catheters (Sherwood Medical, St. Louis, MO) without routine heparinization or placement of an arterial sheath. After the completion of the procedure, the catheter is withdrawn and manual compression maintained until hemostasis is achieved. A pressure dressing is applied.

The post-catheterization protocol is seen in Table 7. The patient is returned by stretcher to the outpatient recovery area where the supine position is maintained for 2 hours. Vital signs are monitored every 15 to 30 minutes. After completion of bedrest, the patient is asked to stand and walk. After 30 minutes, the patient's activities are unlimited and he is discharged from the hospital. The pressure bandage is removed the following morning. A post discharge telephone call is made regarding information on the presence of a hematoma, puncture site pain, or other complications.

Benefits of Outpatient Cardiac Catheterization

As seen in Table 8, there are several benefits of outpatient cardiac catheterization. Enhanced utilization of the cardiovascular laboratories and personnel are realized by the use of outpatient cardiac catheterization. These two features lead to cost containment. As noted by Block in the prospective randomized trial of in-patient vs outpatient diagnostic catheterization, total catheterization related charges per patient were $679 lower for outpatients with a savings of total hospital charges of $885/patient.[22]

The benefits extend beyond facility and personnel cost containment. Patient satisfaction is significantly improved by avoiding long, tedious supine bedrest. 5F diagnostic catheterization reduces the recovery time by two-thirds when compared to 8F catheter systems. Additionally, in-patient admission and discharge on the same day allows the patient to lose less time from his daily activities including employment.

Summary

The extension of coronary arteriography into the out-patient population provides more rapid assessment and determination of severity of coronary artery disease in a primary care and referred base population. The speed of the procedure and reduced recovery period are reflected in enhanced cost containment and improved patient compliance and satisfaction. Further technological advancement in this rapidly developing technological field continues to provide improved patient care.

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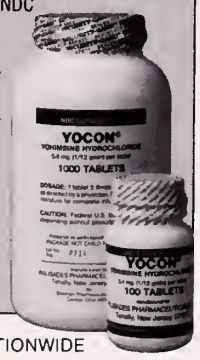

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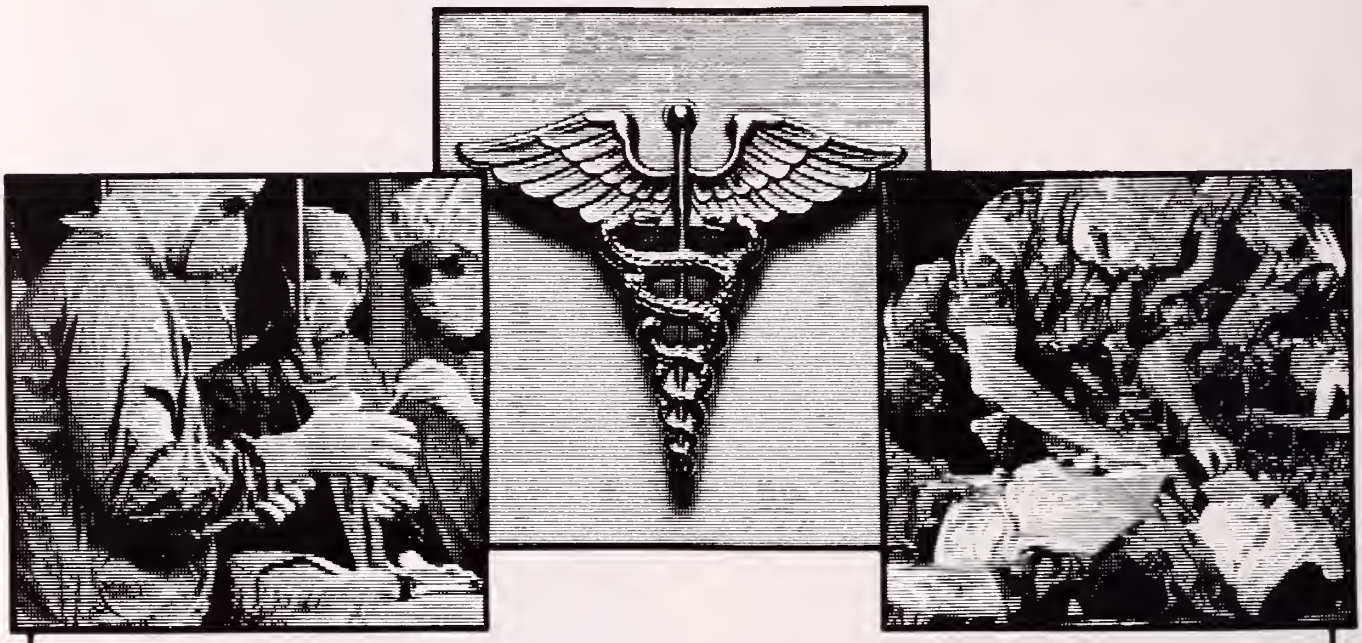

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Current Management of Soft Tissue Sarcomas

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Soft Tissue Sarcomas

The term sarcoma originates from the Greek meaning fleshy growth. These malignant neoplasms of mesenchymal origin are classically described as having a "fish flesh" appearance across their cut surface. The term soft tissue refers to the extraskeletal connective tissues and the muscles of the body that connect, support, and surround other discrete anatomical structures and make up over 50% of total body weight. In spite of comprising the majority of the total body mass, these soft tissues rarely undergo malignant transformation.

Malignant tumors are categorized either as sarcomas or carcinomas. If they arise from connective tissue, they are referred to as sarcomas, or if they arise from the epithelial tissue, they are carcinomas. Tumors of epithelial origin are more common than tumors of connective tissue origin, which is clearly illustrated by the 1989 diagnoses of more than 200,000 gastrointestinal carcinomas but fewer than 6000 soft tissue sarcomas.[1]

Diagnosis and management of the malignant lesions is difficult, with approximately 150 to 180 histological subtypes of soft tissue tumors currently described. The pathological classification presents difficulty distinguishing benign lesions from locally aggressive, nonmetastasizing lesions and from those that are malignant with a propensity for relatively early metastases.

Epidemiology

As with most solid tumors, the cause of malignant transformation is not known for the majority of sarcomas. There is no proven genetic disposition. They are thought to occur with slightly increased frequency in patients with a variety of genetically transmitted diseases, such as the basal cell nevus syndrome, tuberous sclerosis, Werner's syndrome, intestinal polyposis, and Garner's syndrome. Patients with Von Recklinghausen's disease (multiple neurofibromatosis) have an approximately 15% chance of developing a neurofibrosarcoma.

Association between the development of sarcomas and other malignant neoplasms has not been discovered. The lymphangiosarcoma of the upper extremity that occurs after a mastectomy and axillary lymphadenectomy in women who are treated by postoperative radiation therapy does not represent evidence of an etiological correlation between breast carcinoma and sarcoma of the soft tissue, but rather the development of lymphangiosarcoma in a lymphedematous extremity. There is a positive correlation between osteosarcomas and radiation therapy, but sarcomas of soft tissue origin are not associated with a history of prior radiation exposure. Most patients who present with a sarcoma also tend to have a recent history of trauma. There is, however, no etiological relationship, and it is more likely that minor trauma calls attention to the preexisting lesion.

Sites of Soft Tissue Sarcomas

Connective tissue of mesodermal origin is ubiquitously distributed throughout the body. Soft tissue sarcomas can therefore arise from practically any site. Approximately 40% of soft tissue sarcomas occur in the lower extremity, with 75% of these occurring in the thigh region. The proximal thigh is the most common site of soft tissue sarcoma origin. The upper extremity is the site of about 15% of soft tissue sarcomas, while the trunk accounts for about 30%. Those arising from the trunk include lesions of the retroperitoneum (10% of truncal lesions). The head and neck accounts for approximately 15% of sarcomas.

Classification

The histological variability of soft tissue sarcomas was first recognized in the 1930s when the first staging system for sarcomas was devised based on histogenic origin.[2] With a large number of histogenic subtypes and a similarity between subtypes, early histogenic classification schemes proved to be difficult for pathologists to accu-

Table 1. Distributian af Grade by Histalagical Subtype*

Histagenic Subtype	Grade
Dermatafibrasarcama pratuberans	I
Well-differentiated lipasarcama	I
Myxaid liposarcama	I
Rhabdomyasarcama	III
Synavial sarcama	III
Neurablastama	III
Malignant Schwannama	III
Mesenchymal Chandrasarcama	III
Extraskeletal Ewing's Sarcama	III

* Histagenic subtypes nat listed are distributed aver grades I-II, I-II-III, ar II-III.

rately determine subclassification. This, in part, remains true today. Agreement on the histopathological diagnosis of 216 consecutive sarcoma patients in a recent study could be reached in only 66% of the cases.[3]

By the 1960s, it was evident that the histogenic staging system did not correlate with survival. Historically, as far as the pathological findings of the biopsy were concerned, the best prognostic factor was tumor grade. Classification according to histogenic origin was only recently proved to be helpful. Beginning in the 1980s, an appreciation of the interplay between histogenic subtyping and grading in determining the biological behavior of sarcomas was emphasized. Table 1 illustrates the distribution of grade according to histogenic subtype. Grade may be defined by the histogenic subtype of some carcinomas while other more heterogenous subtypes may span the entire spectrum of grade.

Tumor size and site are equally important factors in determining biological behavior. When size is taken into consideration, the difference according to site becomes insignificant. The unrecognized growth of tumors concealed deep within the retroperitoneum and proximal thigh causes delayed diagnosis, larger size at detection, and a poorer prognosis than more easily detected peripheral extremity lesions. Our current staging system for sarcomas reflects the prognostic factors outlined above (Table 2).

Table 2. American Jaint Cammittee Staging System

Stage	Description
IA G1T1N0M0	Grade I tumar less than 5 cm in diameter with na regional lymph nade ar distant metastases
IB G1T2N0M0	Grade I tumar 5 cm ar greater in diameter with na regianal lymph nade ar distant metastases
IIA G2T1N0M0	Grade II tumar less than 5 cm in diameter with no regional lymph nade ar distant metastases
IIB G2T2N0M0	Grade II tumar 5 cm ar greater in diameter with na regianal lymph nade ar distant metastases
IIIA G3,T1N0M0	Grade III tumar less than 5 cm in diameter with na regional lymph node ar distant metastases
IIIB G3T2N0M0	Grade III tumar 5 cm ar greater in diameter with na regianal lymph nade ar distant metastases
IVA G1-3,T1-2,N1M0--	Tumar af any grade or size with metastases ta regional lymph nodes, but na distant metastases
IVB G1-3,T1-2,N0-1,M1	Clinically diagnased distant metastases

Abbreviatians: T = primary tumor; T1 = tumor less than 5 cm; T2 = tumor 5 cm ar greater; G = histalagic grade of malignancy; G1 = law; G2 = moderate; G3 = high; N = regianal lymph nades; N0 = na histalogically verified metastases ta regianal lymph nodes; N1 = histalagically verified regianal lymph nade metastasis; M = distant metastasis; M0 = na distant metastasis; and M1 = distant metastasis.

By understanding the particular biological behavior associated with various histogenic subtypes and the importance of tumor size and grade in predicting the potential for local recurrence and distant metastasis, a better knowledge of the natural history of these malignant tumors evolved that provided sound clinical judgement for integrating effective treatment modalities having the greatest likelihood of achieving tumor control with the least morbidity.

Diagnosis

Approximately two thirds of patients with soft tissue sarcomas present with an asymptomatic mass. Oftentimes these lesions are deep within muscular compartments away from vital organs and grow to extensive size prior to detection. Asymptomatic masses are sometimes identified when the patient experiences minor degrees of trauma, which ultimately draws attention to the area of the tumor. Pain is present in about one third of patients and generally results from pressure or traction on adjacent nerves or muscles.

There are no completely reliable physical signs or radiographic findings that distinguish benign from malignant soft tissue lesions. Strong consideration should therefore be given to the biopsy of any soft tissue mass. The choice of biopsy technique is most important if the soft tissue mass proves to be a sarcoma.

Since the pathological diagnosis of soft tissue sarcomas is difficult, it is important to provide the pathologist with an adequate tissue specimen. In general, cytological smears obtained by fine needle aspiration are inadequate. Institutions with extensive experience in treating these lesions have only now begun to explore fine needle aspiration as a diagnostic tool. The minimum tissue sample for the majority of sarcomas should consist of a core needle biopsy (tru-cut biopsy). Core needle biopsies are useful for patients with large soft tissue tumors that are relatively homogenous and solid on computerized tomography scans. The vast majority of patients, however, require either an incisional or excisional biopsy for diagnosis.

In most cases, the diagnosis of a soft tissue sarcoma is unexpected at the time of incisional or excisional biopsy. Even the most soft and pliable subcutaneous nodule thought to be a lipoma occasionally proves otherwise. The biopsy or excision of a soft tissue mass should be planned so that the biopsy incision may be removed during the subsequent radical excision in case the lesion is malignant. This has been and is the most common error in 20th-century management of soft tissue sarcomas and occurs primarily because benign lesions that may be treated by any incision are common, and sarcomas, which require precise placement of the incision, are rare.

Orientation of the biopsy incision in relation to underlying muscles cannot be overemphasized because improper placement of the biopsy incision may preclude proper radical resection, which can require more extensive radiation fields to encompass all areas of potential contamination. Incisions on the extremities should be placed longitudinally so as not to comprise muscle group excisions. At other sites the incision should be parallel to the long axis of the underlying principle muscle. Biopsies of lesions in the buttocks should be placed as inferiorly as possible to allow for subsequent development of skin flaps for hemipelvectomy if necessary.

Soft tissue sarcomas grow in the path of least resistance and compress surrounding tissue. This surrounding tissue forms a pseudocapsule and contains foci of invasive malignant tissue. Excision through the pseudocapsule often spreads tumor into the surrounding tissue planes of loose areolar tissue and may extend the magnitude of tumor involvement and complicate further surgical treatment. For this reason, excisional biopsy should be limited to the diagnosis of soft tissue sarcomas less than 3 cm in diameter. Potential sarcomas measuring greater than 3 cm in diameter should be biopsied by a carefully placed small incisional biopsy. This technique allows for the acquisition of an adequate wedge of tissue with minimal disruption of surrounding tissue planes. The importance of excellent hemostasis cannot be overemphasized because inadequate hemostasis contaminates the operative field and the adjacent, loose areolar tissue planes with malignant cells. It also increases both the extent of extirpative resection and the size of the field of radiation therapy.

Treatment Preparation

Choice of definitive treatment by amputation, radical compartmental resection, or wide local excision with pre- or postoperative radiation therapy, requires proper tumor staging and a detailed assessment of the patient's treatment risk. The most important component of determining the extent of the primary sarcoma and any subsequent extirpative operation is the physical examination. Careful physical examination with de-

lineation of the location, mobility, potential fixation, or impingement of adjacent vital structures frequently determines the extent of tumor involvement and the operation required for resection. Plain radiograph may show evidence of erosion or invasion of adjacent bone. Computerized tomography scans are useful and often predict the extent of surgery necessary for tumor extirpation. These scans also allow the surgeon to anticipate the degree of postoperative morbidity while planning rehabilitation. Magnetic resonance imaging has recently been reported as helpful in delineating the extent of the soft tissue tumor.[4] Arteriography is useful in delineating the relationship of the sarcoma and major blood vessels in planning the resection and reconstruction of major blood vessels. Bone scans guide physicians when they perform bone or near bone resections that may be closely approximated or invaded by the sarcoma.

The chest radiograph is the most effective diagnostic tool for determining distant metastasis. In the presence of a normal chest radiograph, computerized pulmonary tomography adds little to diagnostic efficacy and increases costs (Table 3). Approximately 10% of patients who present with a primary sarcoma also have distant metastasis. The lung is the first site of metastasis for the majority of patients with high-grade soft tissue sarcomas and represents the most common site of initial recurrence.

Sarcomas rarely metastasize to regional lymph nodes. The incidence of lymph nodes metastasis is higher in epithelioid sarcomas (20% to 40%), synovial cell sarcomas (15% to 20%), and in rhabdomyosarcomas (10% to 15%).[5] Metastasis to regional lymph nodes for other histogenic subtypes is a rare event (< 5%). Thus, the detailed study of regional lymph nodes by either lymphangiography or computerized tomography is discouraged.

Natural History of Soft Tissue Sarcomas

The serious nature of soft tissue sarcomas stems from their local invasiveness and propensity for local recurrence as well as their early hematogenous dissemination and metastasis, generally to the lungs. As noted previously, there are some features in this heterogenous group of malignancies that are unique to particular histologic subtypes.

Fibrosarcoma — Fibrosarcoma was formerly the most common diagnosis for all soft tissue sarcomas. However, advances in the technology and methods of pathological diagnosis have reclassified many of these lesions. Fibrosarcomas in older series are now classified frequently as malignant fibrous histiocytomas. Currently, the term fibrosarcoma is restricted to growths that are composed of cells and fibers derived from fiber sites. Attempt is made to exclude all fibrous growth derived from other cell types acting as facultative fibroblast.

Rhabdomyosarcoma — Rhabdomyosarcomas are classified as pleomorphic, alveolar, and embryonal. Alveolar and embryonal types usually occur in childhood and may be referred to as juvenile-type rhabdomyosarcomas. The term botryoid indicates the polypoid or grape-like appearance of a subset of embryonal rhabdomyosarcomas that have a propensity for urogenital involvement in infants and children. Embryonal rhabdomyosarcomas are the most common soft tissue sarcomas of children. Alveolar rhabdomyosarcomas are distinguished by slit-like alveolar spaces that are detected at pathological examination. Pleomorphic rhabdomyosarcomas are usually present in adulthood and are often highly anaplastic tumors. The diagnosis of pleomorphic rhabdomyosarcomas from other pleomorphic sarcomas has been aided by immunohistochem-

Table 3. Diagnostic Efficacy of Pulmonary Computerized Tomography Scan

Grade	Probability of Distant Metastasis	Multiplied by	Positive CT Scan Negative CXR*	Equals	Yield
I,II	4/100	x	1/10	=	1/250
III	20/100	x	1/10	=	1/50

* This probability includes those patients presenting with a normal CXR and with a CT scan demonstrating metastasis.
Abbreviations: CT = computerized tomography; CXR = chest radiograph.

ical staining using antibodies specific for muscle proteins.

Leiomyosarcoma — Malignant neoplasms arising from smooth muscle of intestinal, vascular, and other organs are classified as leiomyosarcomas. They commonly occur in the retroperitoneum and are frequently associated with central areas of necrosis at radiographic examination.

Liposarcoma — Liposarcomas are malignant lesions of adipose tissue and are classified as well-differentiated, myxoid, round cell, and pleomorphic. Well-differentiated liposarcomas have a propensity for local recurrence and frequently metastasize late in their course. Liposarcomas span the spectrum of biological aggressiveness with well-differentiated lesions that have a relatively good prognosis. Pleomorphic liposarcoma patients, on the other hand, have only a 20% to 30% survival rate at 5 years.

Synovial Sarcoma — The lower extremities are the most common site of synovial cell sarcomas. They most frequently occur in muscle and are not usually close to joints. They are classified as monophasic, biphasic, and epithelioid. Monophasic classification is characterized by sheaths of monotous spindle cells, while biphasic is evident when there are slit-like spaces or clefts within the tumor.

Neurofibrosarcomas — Approximately 10% of patients with neurofibromatosis develop neurofibrosarcomas. They occur anywhere within the body and are malignant tumors of neural sheath origin.

Angiosarcomas — Hemangiosarcomas most frequently arise in the skin and superficial soft tissue. They are extremely aggressive tumors, resulting in only an approximately 10% 5-year survival rate for patients. Lymphangiosarcomas arise from lymphatic vessels and are always high-grade malignancies. They frequently occur in lymphedematous extremities after mastectomy with axillary lymphadenectomy and radiation therapy. Because of the diffuse nature of these lesions, treatment usually requires radical amputation, most often forequarter amputation.

Malignant Fibrous Histiocytoma — Malignant fibrous histiocytoma is the most common classification of all soft tissue sarcomas. A wide spectrum of disease exists, ranging from lesions that are difficult to distinguish from benign tumors to those among the most aggressive malignancies. Most malignant fibrous histiocytomas occur in the sixth and seventh decade of life.

Table 4. Local control

Study	No. of Patients	Local Control Rates	
		Resection	Amputation
Shiu et al[7]	297	72%	93%
Simmon and Enneking[8]	54	88%	83%

Alveolar Soft Part Sarcoma — The cell of origin of these rare tumors is unknown, and they have no benign counterpart. Their course is more protracted than other sarcomas, although most patients ultimately die of the disease. Many patients develop metastatic disease early and ultimately live 10 to 15 additional years.

Epithelioid Sarcoma — Epithelioid sarcomas are of an unknown cell of origin and arise distally in the extremities. Several authors have noted their association with aponeurotic structures. They have a tendency to spread to noncontiguous areas of skin, subcutaneous fat, and bone. They are among the sarcomas with the highest propensity for metastasis to regional lymph nodes. Recommended therapy often includes amputation and regional lymph node dissection.

Treatment

All effective treatment approaches must involve adequate surgical resection. The history of the surgical treatment of soft tissue sarcomas underscores the importance of modern-day principles of soft tissue tumor excision. In the late 1940s and early 1950s, soft tissue sarcomas were treated by local excision. Local failure rates were frequent (80% to 90%). Because of this high rate of local failure, soft tissue sarcomas were treated with extremity amputation (one joint above the malignant lesion) in the late 1950s and 1960s. Local recurrence rate varied between 5% and 15%, thus amputation became the standard treatment. In the 1970s, greater emphasis was put on careful planning of the surgical resection, considering anatomical muscle compartments so that entire anatomical compartments were removed. This so-called radical compartment resection[6] requires that the tumor be located in an area where a wide margin of normal tissue can be obtained between the tumor and adjacent vital structures. In carefully selected patients, local control rates for those treated with radical compartmental resections have been equivalent to those with similar lesions treated by amputation (Table 4).[7, 8]

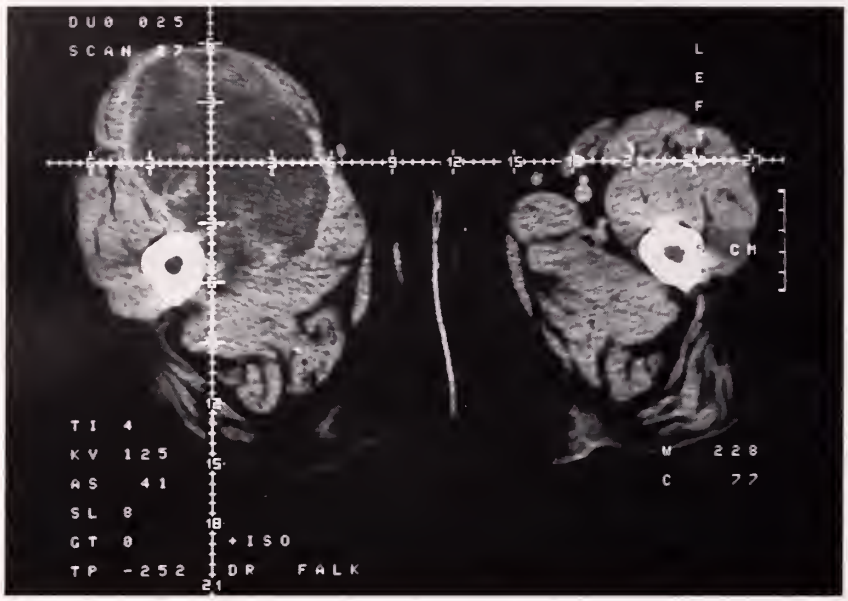

Figure 1. — Computerized tomography showing a myxoid liposarcoma of the anterior compartment of the right thigh. After preoperative radiotherapy, the anterior compartment (femoral, superficial femoral and profunda arteries and veins, vastus medialis, vastus intermedius, rectus femoris and sartorius muscles, and femoral nerve) were resected. The vastus lateralis was preserved and mobilized as a pedicled flap for coverage of venous and arterial interposition grafts. The patient ambulates without supportive brace, with minimal swelling, and little disability.

As radical compartmental resection was pioneered as one method of limb preservation,[7, 8] other groups including Lindberg et al,[9] combined more limited resections (wide local excision to include the pseudocapsule and a limited margin of adjacent contiguous normal tissues) with pre- or postoperative radiation therapy to achieve limb salvage. The rationale for combining the two modalities was that the addition of well-tolerated radiation doses to conservative surgery inactivated the subclinical extension of tumor into the grossly normal tissue adjacent to the obvious tumor mass. By limiting the extent of extirpative surgery, limb salvage with preservation of function can often be achieved (Fig 1). Several studies have concluded that a combination of wide local excision with adequate margins of adjacent normal tissue and either pre- or postoperative radiation therapy yielded rates of local disease recurrence that were equivalent to those achieved by either radical compartmental resection or by amputation.

Rosenburg et al[10] conducted a prospective randomized trial of patients with soft tissue sarcomas of the extremities where patients randomly received amputation at or above the joint proximal to the lesion or wide excision combined with radiation therapy. Both disease-free survival and 5-year survival for the two groups were similar. No local failures were seen in the amputation group, but four local failures occurred in 17 patients whose tumors were located in the thigh. In 10 patients whose tumors were located in the arm, forehand, hand, leg, or foot region, none failed locally. Many other studies have confirmed the conclusion of Rosenberg[10] that wide local excision with pre- or postoperative radiation therapy achieves equivalent overall and disease-free survival rates compared to radical compartmental resection or amputation.

It is important to distinguish wide local excision with a 1 cm or more margin of surrounding normal tissue around the pseudocapsule from the more limited excision done at the time of biopsy. Because the possibility of a connective tissue malignancy is not often appreciated at the time of biopsy, many soft tissue sarcomas are "shelled out" through the pseudocapsule. Such treatment is grossly inadequate alone or in combination with radiotherapy, with over 90% of patients experiencing recurrence locally. The importance of reexcision after biopsy is thus obvious. Even with today's surgical resection standards (wide local excision and postoperative radiotherapy, compartmental muscle group excision, or amputation), local recurrence remains a serious problem. The timing of local recurrence has been consistent from various reported series. Data conclusions from the 1947 study by Cantin et al[11] remain the same today. Cantin found that approximately 80% of all lesions that recur after surgery do so in 2 years. A significant number of patients with a local recurrence may be cured by surgical resection but often also require amputation.

Aggressive pulmonary resection is recommended for the treatment of pulmonary metastasis if the primary sarcoma has been successfully extirpated. Approximately 20% of patients with a resectable pulmonary metastasis can be cured. Approximately 80% of all patients who develop disseminated disease will do so by 5 years after primary tumor resection. This natural history of local recurrence and pulmonary metastasis provides the scientific basis for our current algorithms of follow-up with serial physical exami-

nations of the site of excision, checking for local recurrence, and serial chest radiographs, screening for pulmonary metastasis.

The role of surgical resection and either pre- or postoperative radiotherapy is well-defined, while the therapeutic efficacy of other treatment modalities is less well-defined. Specifically, systemic chemotherapy has been shown to produce responses measured by diminution in tumor size, but the efficacy of either therapeutic or adjuvant adriamycin-based chemotherapy as measured by increased survival or improved quality of life remains controversial.

Summary

Sarcomas are rare. They comprise a heterogenous group of malignancies. Prognosis is determined by presence of distant metastasis, the size of the primary malignancy, and the grade and histogenic classification of the tumor. Careful consideration of the extirpative surgical resection is necessary for appropriate placement of the biopsy incision for diagnosis. Effective therapy includes adequate surgical resection in the form of radical compartmental resection, wide local excision with either pre- or postoperative radiotherapy, or amputation. Progress over the last two decades has resulted in limb salvage and maintenance of limb function for the vast majority of patients.

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The AMA
Hospital Medical Staff Section
Sixteenth Assembly Meeting
November 29 - December 3, 1990
The Peabody Orlando
Orlando, Florida

Highlights of the Interim Meeting will include:

- an educational program on Economic Credentialing;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including Health Care Cost, Waiver of Confidentiality Upon Application for Reappointment and State Hospital Medical Staff Section (HMSS) Oversight Peer Review Committee;
- recommendation of policy to the House of Delegates on Denial of Payment for Pre-Existing Conditions, Third Party Payors and Patient Care Standards;
- AMA-HMSS Governing Council election for the position of Delegate.

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
515 North State Street
Chicago, Illinois 60610
Phone (312) 464-4754 or 464-4761

HMSS

The Doctor-Patient Relationship

In the times of the depression and the great war, the doctor-patient relationship was a stable value, not to be negotiated. The patient paid his own bill either with money and goods or at least with deeply felt and enduring gratitude. The doctor hustled as good a therapy as he could and certainly tempered it with profuse patience and gentle persuasion because time and a favorable natural history of illness were two of his most important tools.

The new era following saw the slow but inexorable development of the third party, then known as medical insurance. The third party intruded little at first. Three cannot live as contained as two, so the cost increased, eventually, like wildfire. Then came the third party doubting the judgements, and eventually the motives, of the second party. Then the third gingerly tried directing the decisions of the second party, received little fuss, so increased its dictatorial powers enthusiastically. The third party still is unable to finance its operation with any comfort so it addresses the first party with changes in operation, then lures of price advantages.

Simultaneously, other economic evolvements are taking place. Back then when a fellow wanted a saw or a pair of britches, he'd go to a store and be served carefully by a clerk or a manager with whom he would agree about the money spent and the desirability of the britches. Then the discount house mentality began a surprisingly firm and inexorable growth until established retail merchandisers finally were obliged to adapt their operations to resemble, then be the same as, discount houses in order to continue financing their operations with any comfort.

Now we hope, for his sake, the first party spends a lot more time and has a lot more fun hanging out in general stores, department stores, haberdasheries and discount houses than he does hanging out in doctors' offices and hospitals. When the third party hustles him with price advantages and coverages which sound better to him but sound worse to the doctors and hospitals, he has learned to grab it without inspecting it too closely or inspecting the pitch of the salesperson, if there is one. He may have failed to foster his affection for the doctor-patient relationship as much as the doctor, understandably, did.

Take two aspirins and call your carrier in the morning, Monday through Friday only.

A. Evan Overstreet, MD
Editor

'In the times of the depression and the great war, the doctor-patient relationship was a stable value, not to be negotiated.'

Make Your Reservations Now

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 24-27. The Hyatt Regency Louisville will be the Headquarters Hotel (Phone (502) 587-3434). In making your reservations, remember the first House of Delegates meeting will be Monday, September 24. Be sure and identify yourself as a KMA meeting attendee to receive the special convention rate.

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Invitations From the AKMA

Join Us For Fall Board

Please attend the AKMA meeting September 24-25, 1990, at the Hyatt Regency in downtown Louisville, Kentucky. The Hospitality Room will be open Monday from 9:30 AM to 3 PM with registration on the second floor of the hotel from 9:30 AM to 2 PM. Even if you are not a member of AKMA, you are welcome to visit with us.

Of course, we would be happy to have you as a member either through your county or as a MAL (member-at-large). If you want any more information about becoming a member, ask in the Hospitality Room.

On Tuesday, the AKMA Board Meeting will be at 9 AM. All are welcome.

I want to extend to each of you a special invitation to a presentation at the KMA Building at 4 PM on September 24. When our past president, Carol Franks, was president of AKMA, her board won a membership challenge from the state of Virginia. A dogwood tree was the prize. After much anticipation, the dogwood will be planted on the KMA grounds.

Betty Schrodt
AKMA President

FALL BOARD SCHEDULE

MONDAY, SEPTEMBER 24

9:30-3:00	AKMA Hospitality Room
9:30-2:00	Registration — Hotel Second Floor
10:00-3:00	COMMITTEE MEETINGS — Regency South A
4:00	DOGWOOD TREE PLANTING — KMA Headquarter Bldg
5:00-6:30	U OF L ALUMNI RECEPTION
6:00	KEMPAC DINNER (Tickets available 2nd floor)

TUESDAY, SEPTEMBER 25

7:30-9:00	AKMA Hospitality Room
8:00-12:00	Registration — Hotel 2nd floor
9:00	BOARD MEETING — Conference Theater
12:30	LUNCHEON — Regency Center "Improving *Our* Image"
5:30-7:00	RECEPTION FOR KMA PRESIDENT — Preston Nunnelley, MD AKMA PRESIDENT — Betty Schrodt

Join Us — Help Kentucky Be A Winner

The Auxiliary to the Kentucky Medical Association is looking forward to another year of commitment to raising funds for the American Medical Association Education and Research Foundation, better known to our members as AMA-ERF.

Last year, with the support of Physicians throughout Kentucky, our members raised $63,682.64. Each contributor can designate their donation to the medical school of their choice. These funds can also be designated to either the Medical Student Financial Aid Fund or the medical school's Excellence Fund, or divided between them. One thing we stress is that the money is always used as directed by each donor. Your check is made payable to AMA-ERF.

We are pleased that Kentucky received awards at the AMA Auxiliary House of Delegates Meeting in Chicago, June 26th. We raised the fifth largest amount per state in the nation. The Boyd County Medical Society Auxiliary was awarded a certificate for being first in the nation on a per capita basis for countywide fund raising ($243.26) and fifth greatest total for a County ($17,515.00). They continue each year to be among the top nationwide for county fund raising for AMA-ERF. Kentucky was the second largest for state contributions, per capita, nationwide ($53.54). We were also honored for having a 22% increase in total funds raised for AMA-ERF. Kentucky was one of the few state auxiliaries in the nation to raise over $50,000 and we had the greatest increase in Medical Student Spouse membership.

Last year, Gloria Griffin and Alice Cowley, State AMA-ERF Chairmen, worked long and hard to reach beyond the goal they set for the year. It not only takes work, but we also need the ongoing support of all auxilians and physicians throughout Kentucky to help insure quality medical education for now and in the future. We ask that you help us in this worthy cause by giving your donations to your medical school through the Auxiliary or by including AMA-ERF in your charitable contribution plans for this year. This is how Tennessee, California, Florida, and Ohio had totals exceeding Kentucky.

The theme for the auxiliary this year is "IMPROVE THE IMAGE OF MEDICINE." With your help we can do our part to accomplish this goal and keep Kentucky among the first to care about the future of medicine.

Katie Roser
AKMA Chairman for AMA-ERF

ATTENTION!

MAKE SURE YOUR PLANS ARE MADE TO ATTEND THE 28TH ANNUAL KEMPAC SEMINAR-BANQUET

SENATOR MITCH McCONNELL

and

HARVEY I. SLOANE, MD

have been invited as guest speakers

Monday, September 24, 1990
6:00 PM EDT — Reception
7:00 PM Dinner with program
to follow
Regency Ballroom North
Hyatt Regency Hotel
Louisville, Kentucky

TICKETS ARE ON SALE NOW! They can be purchased from the KEMPAC Headquarters Office for $25.00 each. Make check payable to KEMPAC and mail to: KEMPAC, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.

28th KEMPAC Seminar-Banquet — $25.00 per person.

NAME _____

ADDRESS _____

CITY _____

Amount enclosed $_____ No. of tickets _____

Lieutenant Governor Jones Awarded AMA Citation

Lieutenant Governor Brereton C. Jones has been awarded the AMA Citation of a Layman for Distinguished Service. The Award was presented at the AMA Annual Meeting in Chicago on June 24. Lieutenant Governor Jones was honored for his role in helping create the Kentucky Medical Association's Kentucky Physicians Care program and the Kentucky Hospital Association's Fair Share program which provides free medical care to indigent people. Since its inception, the program has certified 73,444 eligible Kentuckians and referred 32,280 for care, resulting in an estimated 129,000+ physician encounters.

In presenting the Award the AMA noted:

> Mr Jones recognized a human need, devised a program, and brought diverse elements together to solve the problem. Through his untiring efforts and substantial financial commitment, a simple program whereby poor people could call an 800 number and receive medical care was implemented.

The AMA Citation of a Layman For Distinguished Service is presented annually to an individual not of the medical profession who helps achieve the ideals of medicine by cooperation or aid in the advancement of medical science, medical education, or medical care. *kma*

1989-90 AMA President Alan R. Nelson, MD (R), presented the award to Lt Governor Jones.

KMA President Nelson B. Rue, MD, is seated with Lt Governor Jones and his wife Elizabeth.

To the Editor:

Report of KMA Delegate to 1990 Quinquennial Meeting of the United States Pharmacopeial Convention, Inc

In 1820, 11 physicians representing various geographical regions of the country met in the first Pharmacopeial Convention. They convened to meet a need they perceived — to establish standards for the pharmaceutical products being used to treat patients of that time. The organization they formed gradually expanded to include pharmacists and others, and exists to the present time.

What the USPC Is and Does

The United States Pharmacopeial Convention (USPC), Inc is an organization responsible for the setting of standards for the drug products prescribed by physicians, the production of chemical standards used in research and manufacturing, and the publication of volumes relating to various health care issues involving drug products. The most important work of the organization is acknowledged to be the publication of two official compendia of drug products. These compendia, *The U. S. Pharmacopeia* (USP) and *The National Formulary* (NF), are internationally recognized as the authentic source of drug standards. Most of the states in the US require that all pharmacies have current copies on their premises for reference by their pharmacists.

It also publishes informational books for consumers and professionals. These include the *USP DI for Providers* and the *USP DI, Advice for the Patient,* which provides drug information about more than 4000 commonly prescribed drug products.

Delegates to the United States Pharmacopeial Convention represent state medical associations, colleges of medicine and pharmacy, state pharmaceutical associations, the American Medical Association, the American Pharmaceutical Association, the US Food and Drug Administration, plus representatives from the pharmaceutical industry, consumer groups, and other government agencies. The Convention meets every 5 years unless there is a called meeting (which has occurred only once during the past 20 years). The delegates are appointed or elected by their various organizations for a term of 5 years beginning with each regular meeting of the Convention.

The Convention is unique in that it exists primarily to elect the Committee of Revision. This committee is comprised of some 116 experts in the various fields of pharmacy, pharmacology, and therapeutics, and include faculty from colleges of pharmacy and medicine throughout the country. Its charge is to study the many drugs included in the compendia and revise standards for existing entities, when indicated, and to set compendial standards for new products when they are introduced. The nominees are nominated by their peers in recognition of the contributions which each has made in his or her area of expertise.

In addition to electing the Committee of Revision, the Convention also votes upon revisions and additions to the bylaws and upon the various resolutions presented to the body.

The Kentucky Medical Association has been a progressive supporter of the USPC, having sent a delegate to the Convention for at least the past 20 years. This is remarkable when one considers that only 18 state medical associations were represented at the 1990 Convention, the remainder abdicating their voices in this critical area of health care — an area which impacts on virtually all medical practitioners in the nation who prescribe medications for their patients.

The Meeting

The 1990 Convention was conducted essentially in three sections: (1) scientific presentations, (2) addresses by representatives from many of the sponsoring organizations, and (3) an open forum to discuss resolutions and bylaws changes, and the election of the Committee of Revision, Officers and Trustees of the Convention, and the adoption of resolutions and bylaws changes.

Included in the scientific presentations were: The International Harmonization of Standards; Standards Issues in Biotechnology-derived Products; Quality Problems with Nutritional Supplements; and The Consumer's Need for Quality Standards.

Addresses included ones presented by representatives from The American Medical Association; The US Food and Drug Administration; The American Pharmaceutical Association; The Pharmaceutical Manufacturers Association; and The Nonprescription Drug Manufacturers Association.

Resolutions

Resolutions of interest which were passed included the following, which are paraphrased:

1. USPC is encouraged to replace, reduce, and refine compendial tests that require the use of animals.
2. USPC . . . consider the feasibility and advisability of establishing human in-vivo bioavailability requirements.
3. Expand the program for . . . public standards and information . . . for vitamins and minerals.
4. **[IMPORTANT TO ALL PHYSICIANS.]** USPC develop compendial standards for abbreviations for prescription writing; amended to add that prescriptions will be **written in block letters and measurements**

expressed in metric units. Both the amendment and the amended resolution passed by very close votes, reflecting the concerns spoken to by mostly MD delegates, but also by others as well.

5. USPC . . . develop standard pictograms . . . on prescription labels and information materials.

6. To provide additional and more useful information on drug product equivalence and/or bioavailability in the *USP DI*.

7. Explore with the Food and Drug Administration mechanisms by which reliable data can be generated to establish scientifically sound "beyond use" dates for repackaged products.

8. USPC consider adopting standards for identification of solid oral dosage forms.

9. Consider a policy that droppers on liquid drug products be required to indicate liquid measure (in contradistinction to solid form units such as milligrams).

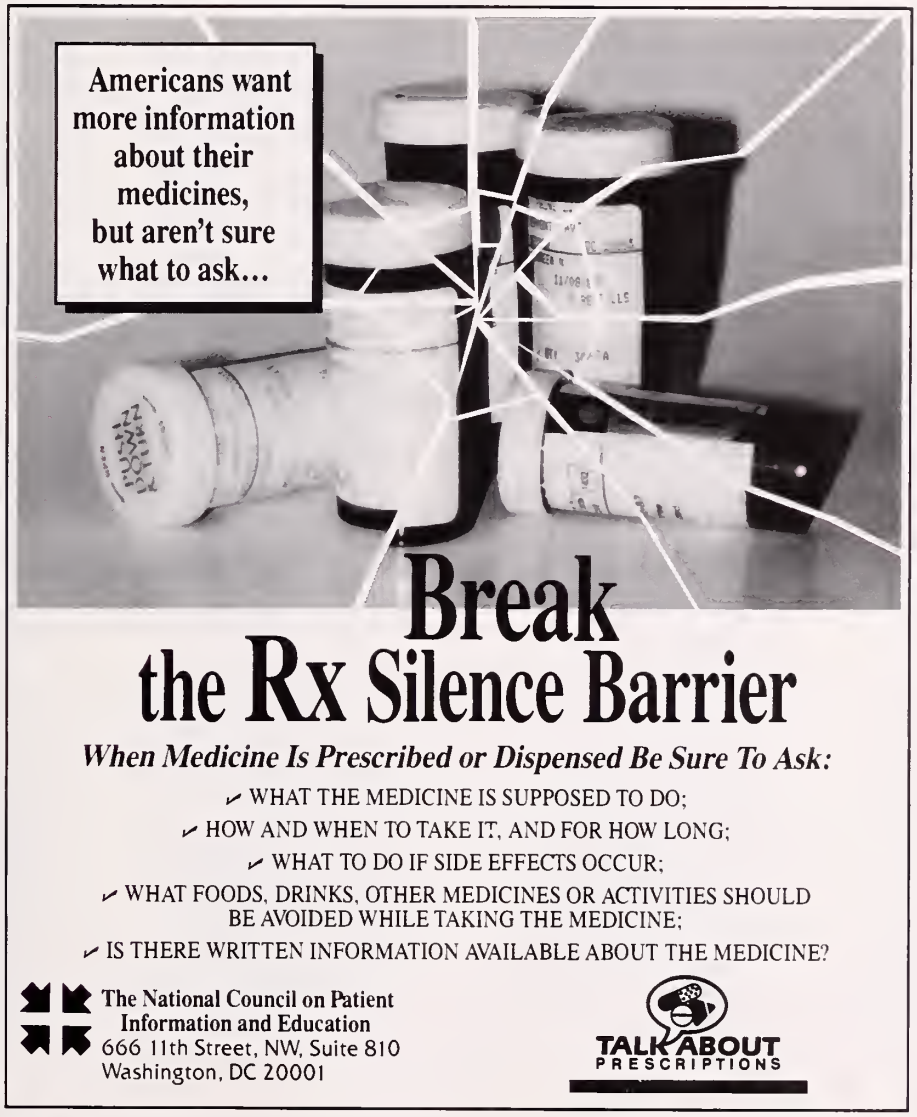
10. Develop USP standards for uniform expiration dating and expiration date labeling for all prescription drug products.

11. USPC continue to develop ways to make *USP DI* a useful resource to health care reimbursement agencies and third party payers.

Twelve additional resolutions were considered which were of less interest to and impact upon physicians.

A summary of the 1990 meeting of the United States Pharmacopeial Convention has been presented. Physicians are encouraged to acquaint themselves with the activities of the USPC and the information it makes available.

E.C. Seeley, MD



Physician Recognition Award Recipients

Listed below are KMA member physicians in Kentucky who have earned the AMA's Physician's Recognition Award (PRA) from July 1989 through June 1990.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Award. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be

Abell, Thomas G.	Campbellsville
Arvin, Orson L.	Mount Vernon
Ball, Christina F.	Louisville
Banis, Joseph C.	Louisville
Barber, George C.	Morehead
Barker, Gary L.	Ashland
Barton, Paul B.	Corbin
Basha, Nabil	Paintsville
Bauer, Richard C.	Madisonville
Baxter, Robert F.	Louisville
Begley, William G.	Bowling Green
Bible, Michael W.	Madisonville
Blair, Richard A.	Louisville
Bowers, Frank R.	Lexington
Boyle, Cornelius D.	Mayfield
Brady, Burns M.	Louisville
Bretz, Robert D.	Louisville
Briscoe, C. William	Corbin
Brown, Manuel L.	Louisville
Bryson, Keith	Bowling Green
Bunge, Robert J.	Lexington
Burchell, Eugene J.	Covington
Burger, J. Timothy	Louisville
Burkhart, Robert C.	Lexington
Burkhart, William K.	Lexington
Burrow, Woody G.	Paducah
Caffrey, P. Raphael	Lexington
Callen, Jeffrey P.	Louisville
Carter, Harry W.	Covington
Cawood, Walter L.	Ashland
Chalothorn, Narong	Prestonsburg
Chaney, George R.	Hazard
Cholera, Vinoobhai M.	Newport
Churney, Alvin M.	Louisville
Clarke, Jeffrey S.	Paducah
Clarke, William F.	Lexington
Collier, Ronald N.	Louisville
Cotthoff, John E.	Hopkinsville
Crabtree, Kenneth R.	Gamaliel
Crocker, Max A.	Lexington
Dawson, Marshall A.	Midway
Dempsey, Robert J.	Lexington
Denison-Humphries, Vinna	Madisonville
Derderian, Harry	Lexington
Dovnarsky, Michael K.	Somerset
Duvall, Victor F.	Clarkson
Egan, Thomas E. J.	Ft. Mitchell
Elbl, Francisco	Louisville
Emslie, Robert J.	Madisonville
Feinberg, Howard L.	Ashland
Fetter, James M.	Frankfort
Friedman, Glenn T.	Louisville
Funke, Harold F.	Crestwood
Geren, John W.	Lexington
Gibbs, Jerry L.	Glasgow
Hagen, Michael D.	Lexington
Hall, Larry J.	Elizabethtown
Hauswald, Kenneth R.	Ashland
Hendren, Robert D.	Bloomfield
Hines, John H.	Shepherdsville
Hubbuch, Anthony	Louisville
Jacob, Robert A.	Louisville
James, Gary V.	Marion
Jelsma, Richard K.	Louisville
Jensen, James C.	Campbellsville
Jones, Dale E.	Mayfield
Kaye, Mitchell D.	Madisonville
Keller, Willliam H.	Frankfort

in Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and nonsupervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour.

We congratulate these physicians who have distinguished themselves and their profession by their commitment to continuing education.

Kelty, Karl C.	Lexington
Kirzinger, Stephen S.	Louisville
Kratz, Robert C.	Newport
Kuebler, Walter J.	Bowling Green
Kuhn, Wolfgang F.	Louisville
Kutnicki, Benjamin	Warsaw
Logan, John A.	Henderson
Longshore, Robert T.	Covington
Maguire, Herbert T.	Louisville
Marshall, Willis H.	Bowling Green
Martin, Cecil D.	Carrollton
May, Sean S.	Hopkinsville
Miles, Richard S.	Russell Springs
Milholen, Linda S.	Stanford
Miller, William L.	Greenville
Mitchell, William H.	Richmond
Moberly, Harold S.	Winchester
Moseley, Mortimer H.	Kuttawa
Mutchler, Bradford E.	Paducah
Myers, Wayne C.	Owensboro
Nunnelley, Preston P.	Lexington
Parks, John H.	Lexington
Parrott, Teri D.	Louisville
Patton, John A. L.	Whitley City
Perez, M. Robert	Bowling Green
Phillips, R. J.	Gilbertsville
Porciuncula, Floro B.	Hopkinsville
Roberg, Bradford C.	Ashland
Rubinstein, Jeffrey B.	Covington
Rumage, William T.	Louisville
Sanchez, Jose A.	Ashland
Sanderlin, Billy E.	Corbin
Sandler, Nat H.	Lexington
Sarkari, Bahadur	Paducah
Schaffer, William A.	Louisville
Schneider, Paul D.	Louisville
Scott, Timothy R.	Lexington
Shafer, Diane E.	Turkey Creek
Shearer, Glenn R.	Lexington
Sides, Paul J.	Lancaster
Simmons, John W.	Monticello
Smith, Clifton	Lexington
Smith, Kenneth W.	Middlesboro
Steinbock, Robert R.	Louisville
Stigall, Robert W.	Danville
Suetholz, David W.	Covington
Swikert, Donald J.	Florence
Swikert, Nancy J.	Florence
Taustine, Lloyd R.	Louisville
Terhune, Jonathan N.	Hopkinsville
Thomas, Joan E.	Louisville
Tsai, Tse M.	Louisville
Tyler, Terry W.	Owensboro
Valera, Erlindo G.	Pikeville
Valera, Remedios M.	Pikeville
Van Meter, Woodford S.	Lexington
Vickers, David H.	Henderson
Wayne, Peter H.	Louisville
Wheeler, Max E.	Ashland
Williams, Wayne E.	Mayfield
Winland, Denise L.	Louisville
Wiss, Mary L.	Pikeville
Wolff, Thomas W.	Louisville
Ymalay, Chito T.	Flatwoods
Yunker, Phillip H.	Maysville
Zalla, James A.	Florence
Zimmerman, Nathan	Louisville

PEOPLE

After dedicating more than 40 years of his life to the field of orthopaedics and 26 years to the University of Kentucky College of Medicine, **Thomas D. Brower, MD**, is retiring from his faculty appointments at the University. Dr Brower, professor of surgery and former chief of the division of orthopaedic surgery, is most noted for his role in laying the foundation for the UK College of Medicine division of orthopaedics.

Dr Brower served as UK's first and, for four years, only orthopaedic surgeon. Today, the division consists of nine orthopaedic surgeons and 12 residents.

Although Dr Brower is stepping down from his faculty appointments and is retiring from his clinical activities, he will teach an anatomy course to UK medical students on a volunteer basis.

Henry C. Vasconez, MD, Assistant Professor of Surgery, University of Kentucky College of Medicine, recently was elected as a Specialty Fellow into the American Academy of Pediatrics. The academy is an organization dedicated to improving the health and well-being of children. Specialty Fellowship status is achieved by physicians from various disciplines who dedicate 50% or more of their teaching, research, and clinical activities to children.

Dr Vasconez has served as a faculty member of the UK division of plastic surgery since 1989. In addition to his appointment at UK, he serves as chief of plastic surgery for the VA Medical Center in Lexington.

The University of Louisville School of Medicine has announced the appointment of **V. Faye Jones, MD**, to the Department of Pediatrics as Assistant Professor of Pediatrics, Ambulatory Pediatrics.

James A. Baumgarten, MD

After serving Kentucky Medical Insurance Company (KMIC) as a director of the board from 1979 to 1986, and since 1986 as a staff member and the board's "director emeritus," **James A. Baumgarten, MD**, has retired. Dr Baumgarten founded and directed KMIC's claims prevention program for doctors and their staffs.

As director of claims awareness and prevention, Dr Baumgarten called upon his 26 years of experience as a radiologist on the staff of the Owensboro-Daviess County and Mercy Hospitals in Daviess County, his many years of working with the KMA and the Daviess County Medical Society on scientific and continuing education programs, and his work with the board.

Dr Baumgarten earned his medical degree in 1955 from Marquette University in Milwaukee, Wisconsin. He has been very active in organized medicine as a member of the American Board of Radiology, Radiological Society of North America, American Roentgen Ray Society, and a Fellow of the American College of Radiology. During his 30 years of membership in KMA, Dr Baumgarten has served on numerous committees including Chair of the Scientific Program Committee for several years.

Walter I. Hume, Jr, MD

Louisville surgeon **Walter I. Hume, Jr, MD**, has been appointed medical director for Kentucky Medical Insurance Company (KMIC).

Recently retired from the practice of medicine, Dr Hume is a clinical professor of surgery at the University of Louisville School of Medicine and has had an active private practice. Dr Hume will serve as the company's medical director and will advise its underwriting, claims, and risk management departments in medical related matters.

Dr Hume, who was on the staff of several Louisville hospitals, has held leadership roles with the Jefferson County Medical Society and board appointments with Blue Cross-Blue Shield Plans of Kentucky and J. Graham Brown Cancer Center.

Dr Hume succeeds the retiring director of claims prevention and awareness, James A. Baumgarten, MD, as Kentucky Medical's staff medical advisor. Along with KMIC's risk manager, Dr Hume will be responsible for studying claims experience and helping develop ways to reduce liability claims.

Oraib Yacoub, MD, Assistant Clinical Professor of Pathology and Pediatrics, has been promoted to Associate Clinical Professor of Pathology at the University of Louisville School of Medicine.

David Allen, MD, Director of Health, Jefferson County Government, and **Betty Bibbins, MD,** were included when the Leadership Louisville Foundation announced the selection of 58 class members for the 1990-91 Leadership Louisville Class. Members meet monthly from August until May to familiarize themselves with opportunities, needs, problems, and resources in the community.

Billy F. Andrews, MD, Professor and Chairman of the Department of Pediatrics, U of L School of Medicine, is the recipient of the Editor's Choice Award of the National Library of Poetry for "How It Feels To Fly."

Michael B. Foster, MD, Associate Professor of Pediatrics, U of L School of Medicine, has been elected to the Board of Directors of the Rural Kentucky Medical Scholarship Fund, Inc.

Russell L. Travis, MD, has been elected to Kentucky Medical Insurance Company's board of directors. Dr Travis, a Lexington neurosurgeon, is a KMA trustee and chairman of its Kentucky Physicians Care Operating Committee which established a program and hotline for assisting indigent patients with medical care. He also is a current member of the Kentucky State Developmental Disability Planning Council.

A new slate of officers was recently elected for the Methodist Evangelical Hospital medical staff. President is **John D. O'Brien, MD;** President-Elect, **Paul A. Fleitz, MD;** and Secretary-Treasurer, **R. John Ellis, Jr, MD.**

Norman M. Cole, MD, was recently elected to the office of President-Elect of the Southeastern Society of Plastic and Reconstructive Surgeons and is currently serving as Vice President of the American Society of Plastic and Reconstructive Surgeons.

Judy Linger, a senior medical student at the University of Kentucky, was elected as Chairperson of the Governing Council of the AMA Medical Student Section at the Section's Annual Meeting in June. Ms Linger will lead the Council until June 1991.

Since attending her first AMA-MSS Annual Meeting at the end of her freshman year, she has held committee appointments at every national convention. Most recently, she served as Vice Chairperson of the Council and is the current AMA Student Representative to the Board of National Resident Matching Program and the AMA-MSS Representative to the Consortium of Medical Student Groups.

As a member of KMA's Continuing Medical Education Committee, she has been an active participant on survey teams to review and certify CME programs throughout the state. Ms Linger has been active in chapter activities of the UK KMA-MSS, having served as Vice President, and is a member of the state Governing Council.

UPDATES

AMA Has a New Address and Phone Number

The staff of the American Medical Association moved on August 27 into leased space in a new headquarters building in Chicago. The AMA's new mailing address is 515 North State Street, Chicago 60610. The general office phone number is now 312/464-5000.

The original AMA headquarters building dated back to 1902, had undergone several additions throughout the years, and was becoming increasingly more expensive to maintain and operate. In 1985-86, the AMA undertook an extensive study to decide what to do about the aging building. A conclusion was reached that the fiscally sound solution would be to become the prime tenant in a developer's larger office building.

UK Opens a Critical Care Center

On July 28, the opening of its Critical Care Center marked another milestone in the University of Kentucky Hospital's commitment to excellence in health care for Kentuckians. The Hospital has always placed a major emphasis on the provision of critical care. That emphasis was the driving force when, more than a decade ago, the Hospital began planning for the Critical Care Center. The Center was designed to accommodate today's technology, as well as to adapt to tomorrow's medical advances.

The new Critical Care Center, located adjacent to the Hospital and visible from Rose and South Limestone streets, houses Central and Eastern Kentucky's only Level I Trauma Center and a new Emergency Department. The six-floor Center has entire floors dedicated to surgery, intensive care, and clinical laboratories. The rooftop is equipped with a heliport and hangar for the Hospital's Aeromedical Service.

U of L Makes History With Transplant

U of L physicians made medical history recently when they gave a 50-year-old father of six a new liver and kidney. The liver transplant was Kentucky's first.

The University reports that the 13-hour surgery was performed at Jewish Hospital by **Frederick R. Bentley, MD,** assistant professor of surgery and head of the hospital's Liver, Pancreas, and Kidney Transplant Team. Dr Bentley was assisted by **Richard N. Garrison, MD,** associate professor of surgery, who led the organ procurement team, and surgery professor **David J. Richardson, MD.**

The patient's liver had been damaged by hepatitis C, a viral infection

most often transmitted through blood transfusion. Most hepatitis patients recover after several months of care and rest. But when extended bedrest failed to alleviate the condition, the patient was referred to professor **Carlo H. Tamburro, MD,** director of the U of L Liver Research Center. Dr Tamburro found that the patient had type "C," a more debilitating kind of virus that sometimes causes liver damage.

According to the University, Dr Tamburro treated the patient with Intron A (recombinant human alpha interferon [alfa-2b]), the only therapy shown effective in treating chronic hepatitis C. When the drug failed to produce remission or reduce liver damage, Dr Tamburro referred the patient to The Transplant Center at Jewish.

Comedy Provides Serious Relief for Cancer Patients

Cancer is no laughing matter. But University of Louisville psychiatry professor **Clifford Kuhn, MD,** is using comedy to help treat cancer patients.

A stand-up comic, Dr Kuhn is studying comedy's effects on his patients. He invites patients to a local club for a free night of laughs provided by professional comedians. The patients then fill out questionnaires and take part in follow-up studies.

Dr Kuhn says there's no proof that laughter cures, but it relieves stress and helps increase a person's tolerance for pain.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Barren

Medha Suwana-Wongse, MD — S
746 E Main Plaza, Glasgow 42141
1969, Chiangmaiu U, Thailand

Boyd

Stephen L. Edge, MD — U
1816 Lexington Ave, Ashland 41101
1978, Georgetown U

Bell

Elias A. Deetlefs, MD — IM
3600 W Cumberland, Middlesboro 40965
1981, U of Stellenbosch, S Africa

Kenny Ratana, MD — R
PO Box 190, Pineville 40977
1970, Mahidol U, Thailand

Christian

Jonathan M. Goodin, MD — PD
2501 S Virginia #13, Hopkinsville 42240
1985, U of S Alabama

Fayette

Steven B. Johnson, MD — S
UKMC — Surgery, Lexington 40536
1982, U of Virginia

Floyd

Raghu R. Sundaram, MD — IM
Archer Clinic, Prestonsburg
1963, Kurnool Medical College, India

Franklin

Vladimir Dvorak, MD — PM
275 E Main, Frankfort 40621
1960, Charles U, Czechoslovakia

Hardin

John T. Logsdon, MD — S
1010 Woodland Dr, Elizabethtown
1982, U of Kentucky

Harrison

William H. Wagner, Jr, MD — OBG
PO Box 654, Cynthiana 41031
1965, U of Kentucky

Jefferson

Thomas D. Cummins, MD — PS
516 Blankenbaker Ln, Louisville 40207
1983, U of Louisville

Robert L. Fulton, MD — TS
601 S Floyd #700, Louisville 40202
1964, Washington U, St. Louis

John F. Klink, III, MD — R
Jewish Hospital-Radiation, Louisville 40202
1985, Indiana U

Mark P. Pfeifer, MD — IM
319 Pleasantview Ave, Louisville 40206
1983, U of Louisville

Clifton M. Tatum, Jr, MD — R
204 Medical Towers N, Louisville 40202
1983, U of Louisville

Madison

Patrick G. O'Daniel, MD — IM
527 W Main St, Richmond 40475
1986, U of Cincinnati

McCracken

Billy D. Bailey, MD — IM
578 Huntleigh Ln, Paducah 42001
1984, U of Louisville

Nicholas

Brenda K. Curtz, MD — IM
226 Eastin Rd, Lexington 40505
1988, U of Kentucky

Northern Kentucky

Thomas R. Antony, MD — OBG
7711 Tanners Lane #106, Florence 41042
1979, U of Louisville

Elliott M. Friedeman, MD — P
259 Riverside Pkwy, Ft. Thomas 41075
1972, U of Florida

Vicki L. Roberts, MD — P
20 Medical Village Dr #213, Edgewood 41017
1984, U of Kentucky

Pike

Rene T. Limjoco, MD — AN
114 Zeigler Dr, Pikeville 41501
1980, U of the Philippines

Pulaski

Piyush Patel, MD — N
104 N Linwood Ct, Somerset 42501
1975, Baroda Medical College, India

Dale E. Rutledge, MD — OBG
104 Hardin Ln, Somerset 42501
1984, U of Louisville

Thomas A. Vacek, MD — C
340 Bogle St, Somerset 42501
1983, St George's U, WI

Rockcastle

William D. Dooley, MD — R
63 Perciful St, Mt. Vernon 40456
1958, U of Cincinnati

David K. McAfee, MD — S
RR 4, Box 41, Mt. Vernon 40456
1953, Northwestern U

Simpson

Jack K. Patterson, MD — IM
PO Box 3013, Franklin 42135
1987, Ross U

New In-Training

UK —
Susan N. Webb, MD — FP

St. Elizabeth —
Marguerite S. Schabell, MD — FP

DEATHS

A. J. Whitehouse, MD
Lexington
1903-1990

A. J. Whitehouse, MD, an OB-GYN, died May 24, 1990. Dr Whitehouse was a 1928 graduate of Cornell University Medical College and a life member of KMA.

Paul B. Hall, MD
Paintsville
1897-1990

Paul B. Hall, MD, a retired surgeon, died June 9, 1990. Dr Hall served as President of Paintsville Hospital for 43 years and also was a surgeon for the C & E Railway Company. A 1923 graduate of the University of Louisville School of Medicine, Dr Hall became an active member of KMA in 1924 and was a life member.

Maher Speevack, MD
Louisville
1899-1990

Maher Speevack, MD, a retired general practitioner, died June 9, 1990. A 1933 graduate of the University of Louisville School of Medicine, Dr Speevack became an active member of KMA in 1934 and was a life member.

John P. Casey, MD
Louisville
1953-1990

John P. Casey, MD, a family practitioner, died June 12, 1990. Dr Casey was a 1981 graduate of the University of Louisville School of Medicine and had been an active member of KMA since 1985.

Kearney B. Daniel, Jr, MD
Danville
1928-1990

Kearney B. Daniel, Jr, MD, a general surgeon, died June 16, 1990. A 1956 graduate of the University of Louisville School of Medicine, Dr Daniel was an active member of KMA.

Robert M. Wooldridge, MD
Paducah
1917-1990

Robert M. Wooldridge, MD, an anesthesiologist and general practitioner, died June 19, 1990. Dr Wooldridge was a 1949 graduate of the University of Louisville School of Medicine. A life member, Dr Wooldridge joined the association in 1953.

Michael B. Nolph, MD
Louisville
1948-1990

Michael B. Nolph, MD, an otolaryngologist, died June 21, 1990. Dr Nolph helped develop a cochlear implant, an "artificial ear" that provides limited hearing to people with certain kinds of deafness, and was one of four surgeons in the country who received federal authorization to test the device in humans in 1984. Dr Nolph graduated from the University of Michigan in 1974 and had been an active member of KMA since 1982.

John E. "Jack" Trevey, MD
Lexington
1933-1990

Republican State Senator John E. "Jack" Trevey, MD, died June 28, 1990. Dr Trevey, a physician for IBM in Lexington, had served in the General Assembly since 1978, and was Republican caucus chairman since 1987. He was a member of the Health and Welfare committee. A 1959 graduate of the Medical College of Virginia, Dr Trevey had been an active member of KMA since 1967.

John B. Floyd, Jr, MD
Lexington
1917-1990

John B. Floyd, Jr, MD, a general surgeon, died July 3, 1990. Dr Floyd was a 1941 graduate of the University of Louisville School of Medicine. He was a former secretary-treasurer of the Fayette County Medical Society, was a president of the Kentucky Chapter of the American Cancer Society and received the chapter's Distinguished Service Award in 1950. In 1967, Dr Floyd received the Contribution Award from the American Cancer Society. He was a life member of KMA.

Leslie Van Nostrand, Jr, MD
Louisville
1924-1990

Leslie Van Nostrand, Jr, MD, a retired psychiatrist and occupational medicine physician, died July 11, 1990. Dr Van Nostrand was former president of the Kentucky Industrial Medical Association and former secretary of the Kentucky Psychiatric Association. A 1947 graduate of Long Island College of Medicine, Dr Van Nostrand joined KMA in 1960 and was a life member.

Gilman P. Peterson, MD
Cave City
1913-1990

Gilman P. Peterson, MD, a retired ENT, died July 23, 1990. A 1937 graduate of the University of Louisville School of Medicine, Dr Peterson was a life member of KMA.

SEPTEMBER

21-22 — Fifth Annual Encoduriether-apy Symposium: New Techniques in Adjuvant Therapy of Cancer, Ohio State University Hospitals' Rhodes Hall Auditorium, Columbus, OH. Contact: Ohio State's Center for CME, 800/492-4445.

22 — Ophthalmic Insights into the 90s. Presented by N. D. Radtke, MD and Humana Hospital Audubon. The conference qualifies for 3.5 hours in Category I of the AMA Physicians Recognition Award. Contact: N. D. Radtke, MD, 240 Audubon Medical Plaza, Louisville, KY 40217, 502/636-2823.

28-29 — Fifth Annual Multispecialty Oculoplastic Surgery Symposium. Contact: Karen Heidorn, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 N Eagle Creek Drive, Lexington, KY 40509, 606/268-3754.

OCTOBER

4-7 — American Society of Internal Medicine 34th Annual Meeting, "Ethics and Efficacy: A Script for the '90s," Beverly Hilton Hotel, Beverly Hills, CA. Contact: Jane M. Anderson, 1101 Vermont Avenue NW, Suite 500, Washington, DC 20005-3457, 202/289-1700.

5 — Multiple Sclerosis 1990: Genetic Factors in MS, Hyatt on Capitol Square, Columbus Ohio. Sponsored by Ohio State University's Center for CME. Contact: Ohio State's Center for CME, 800/492-4445 or 614/292-4985.

14-17 — Southern Medical Association's 84th Annual Scientific Assembly, The Opryland Hotel, Nashville, TN. Contact: Kathy McLendon, Communications & Marketing Assistant, SMA, PO Box 190088, Birmingham, AL 35219-0088, 205/945-1840.

NOVEMBER

1-3 — Clinical Allergy for the Practicing Physician , The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by Washington University School of Medicine. Program Chairman: Phillip E. Korenblat, MD. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110; 800/325-9862, 314/362-6893.

9-10 — 24th Annual Newborn Symposium and 4th Fall Symposium of the Kentucky Pediatric Society, The Seelbach, 500 Fourth Ave, Louisville, KY. Contact: Lynette McInnis, 502/588-5329.

1991

FEBRUARY

Feb-April — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology, Home Study Course A, The Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, 301/955-8594.

MARCH

8-9 – 4th Annual Contact Lens Course, Washington University Medical Center, St. Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110, 800/325-9862 or 314/362-6893.

APRIL

11-13 — Treatment of Surgical Spine Disease, The Ritz-Carlton Hotel, St. Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110, 800/325-9862 or 314/362-6893.

14-25 — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology, In-Residence Course B, The Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, 301/955-8594.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

WESTERN KENTUCKY — Seeking physicians for evening and weekend coverage in a low volume emergency department. Attractive schedule and compensation. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc, 2240 South Airport Road, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

INTERNAL MEDICINE — FAMILY PRACTICE — Excellent private practice opportunity in western Kentucky to join another physician in a busy practice. Competitive compensation package with shared call coverage. Send CV to: Don Hoit, 11222 Tesson Ferry Rd, Suite 203, St. Louis, MO 63123, or call-1-800-336-3963.

FOR LEASE — Office suite approximately 1,100 square feet. Located in Bardstown, KY at high visibility location. One block from hospital. Within walking distance of schools and business district. Could be shared as satellite office. Call: 348-6404 Tuesday-Friday or 348-5480 after 7 pm.

MARK YOUR CALENDAR

140TH ANNUAL MEETING KENTUCKY MEDICAL ASSOCIATION SEPTEMBER 24, 25, 26, 27 HYATT REGENCY HOTEL & LOUISVILLE CONVENTION CENTER

LOUISVILLE

SEPTEMBER 24 & 26 MEETINGS OF THE HOUSE OF DELEGATES

SEPTEMBER 25, 26, 27 GENERAL SCIENTIFIC SESSIONS

Help gain control of diabetes

Meet the standards of diabetes care in the 1990's and take pride in your practice.

Please attend the American Diabetes Association clinical education program sponsored by the American College of physicians and the American Diabetes Association Kentucky Affiliate.

Kentucky Medical Association Meeting
Louisville, Kentucky
Wednesday afternoon session
September 26, 1990

CAGE
Questionnaire

For the Diagnosis of Alcoholism

C = Have you ever felt you should **cut down** on your drinking?

A = Have people **annoyed** you by criticizing your drinking?

G = Have you ever felt bad or **guilty** about your drinking?

E = Have you ever had a drink first thing in the morning **(eyeopener)**?

Positive CAGE Answers:

1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

KENTUCKY MEDICAL ASSOCIATION
Committee on Impaired Physicians
3532 Ephraim McDowell Drive
Louisville, KY 40205
(502)459-9790

1990 ANNUAL MEETING

ATTENTION
SENIOR PHYSICIANS!

Continental Breakfast
Wednesday, September 26
10:00 am
Louisville Hyatt Regency
Kentucky Suite (2nd Floor)
320 West Jefferson Street

Fee: $8.50

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OCT 23 1990

Preston P. Nunnelley, MD
KMA President 1990-91

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• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

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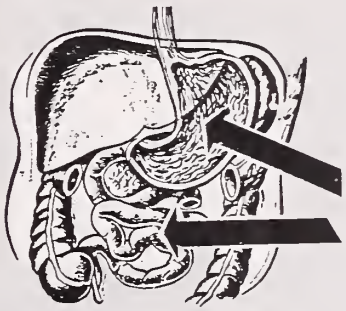

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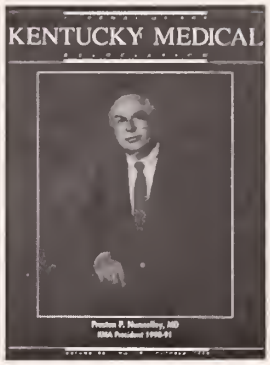

COVER: Preston P. Nunnelley, MD, Lexington, was installed as KMA's 140th President on September 26, 1990.

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Pride in Medicine

The following is the inaugural address given September 26 by Preston P. Nunnelley, MD, Lexington, as he assumed the presidency of the Kentucky Medical Association.

'No other profession offers so much in terms of pure joy and sense of accomplishment.'

As a theme for the 1990-1991 year, I have chosen "Pride in Medicine." While the Association will maintain a vigilant federal and state legislative effort, our emphasis in 1990-91 will be promoting the profession as a worthy goal and developing pride in our individual and collective accomplishments. At a time when the credibility of our profession is questioned and there is a tendency to circle the wagons, we must reassert ourselves and once again take pride in our accomplishments and the role we play in society.

A study done by the American Medical Association in 1989 revealed that 40% of the doctors interviewed said that they would definitely or probably not enter medical school if they had a career choice to make again. From this survey and discussion with colleagues, we can understand the frustrations brought about by the intrusion in the traditional physician-patient relationship that has reached crisis proportions and threatened lives of patients and careers of physicians. Bureaucratic bungling, payments for services as low as 10% of the usual fee, 15% to 20% of all patients with no insurance, many without jobs, frustrates us all. Many physicians and health care workers are filled with anger and hopelessness. They work with life-threatening conditions realizing that major decisions on patient care are often dictated by someone at the other end of the phone.

However, all is not gloom and doom! The Russians are not coming and it appears that a national health plan is not imminent. Positive things are happening in patient care, relationships with coworkers, and in the area of health cost. We have a great deal to be proud of and look forward to.

While I am not an advocate of public relations campaigns to embellish physicians, insurance, or oil company reputations, I do believe that we can do a better job of documenting and publicizing our achievements without being defensive and without being apologetic. The health care industry has every right to demand respect for our contributions to health care, for our productivity, and our standards.

Our primary mission and responsibility is to our patients, who are bombarded every day with criticism of the system. They are cautioned to be more consumer oriented and urged to treat doctors offices like supermarkets. Consequently, patients inundated with the announcement of medical breakthroughs and innovations from the broadcast and print media, expect the impossible, or as John

Steckle of Massachusetts General Hospital said of the public's expectations, "All diseases are treatable and there should be no pain or suffering." In that context, Charles Bernard Shaw wrote, "We have not lost faith but have transferred it from God to the medical profession." Blinding technological advances and other medical innovations have allowed us to reattach limbs, transplant hearts, treat fetuses, and perform surgery without incision. We have become victims of our own success and occasionally the scorn of the public, which expects more than we can deliver. Dr C. Everett Koop said recently, "I am convinced that patients do not like doctors and that doctors no longer like their patients." This is a sad commentary on the patient-physician relationship. If we are to accomplish any of our goals, we must change this perception. It has been estimated that 75% of the US population visits a physician at least once a year. Face-to-face contact with three-fourths of the American population, organized and utilized properly, can go a long way in changing our image. We need to use these valuable minutes to show our interest in the patient's welfare and recognize them for who and what they are. It is also a time when we can educate our patients on the external intrusion into the practice of medicine.

'. . . I do believe that we can do a better job of documenting and publicizing our achievements without being defensive and without being apologetic. The health care industry has every right to demand respect for our contributions to health care, for our productivity, and our standards.'

'. . . We must reignite the fire that existed within us when we chose to become physicians, for the task ahead will not be easy.'

Despite all this, my pride in this profession is not diminished and grows stronger every day. Maybe Kentuckians are an exception in an uncaring, selfish world. Health providers in Kentucky have formed a unique alliance with the public and government to provide medical care for our uninsured and indigent. Since 1985 KMA's Kentucky Physicians Care program, with over 2300 Kentucky physicians participating, has certified 71,000 individuals, taken 67,000 phone calls and made 31,000 referrals of sick patients to participating Kentucky physicians. The Kentucky Hospital Association's "Fair Share" program began at the same time and every Kentucky hospital is a participant. We were extremely thrilled recently when the Kentucky Pharmacists Association, in a unique arrangement with Pfizer Laboratories, began providing poor Kentuckians drugs without cost. The pharmacy and drug industry, along with physician and hospital programs, completes a "circle of health care" for dispossessed and poor Kentuckians.

In 1989, the Jefferson County Medical Society assumed responsibility for a mission for the homeless which serves 175,000 meals annually and provides more than 80,000 nights of lodging. In addition, both Ronald McDonald Houses in Kentucky were products of Kentucky physician and spouse interest in providing lodging for families and patients.

'By discouraging young people from becoming physicians, we destroy ourselves from within. We need that innovative, energetic young person to carry the torch of medicine and the profession.'

I have only mentioned a few projects in which our profession is involved. This fails to take into account

'In the 90s we will experience startling advances in medical care and technology, far surpassing anything we have seen in our lifetime. This will be an exciting time in the health delivery system and an extraordinary time to be a physician.'

individual contributions and sacrifices made every day by physicians and their families which contribute to our pride in medicine. Physicians are major contributors to KET and similar benevolent and educational causes and institutions. Last year the Auxiliary to KMA raised over $50,000 which was contributed to the medical schools in Kentucky.

Physicians, spouses, and families serve communities in many capacities, including school boards, boards of health, and various commissions. At every major high school athletic event, you will find a physician on the bench serving without charge as team physician.

'Face-to-face contact with three-fourths of the American population, organized and utilized properly, can go a long way in changing our image.'

Too often we downplay the opportunities afforded us and the obligation we have to society and patients. We can preserve those opportunities and fulfill those obligations only so long as we maintain the freedom to practice and the will to survive. There is a despondency within the profession by those who are leaving or simply saying, "I'm glad I'm not just starting out." There is nothing more discouraging than having a colleague say, "I talked my son or daughter out of going to medical school." By discouraging young people from becoming physicians, we destroy ourselves from within. We need that innovative, energetic young person to carry the torch of medicine and the profession. Between 1983 and 1989, medical school applications were down 23.5%. This is a disturbing trend, but I believe that a newfound pride in medicine will reverse this trend. No other profession offers so much in terms of pure joy and sense of accomplishment. Perhaps that explains why the road is so difficult from the beginning of medical school to the completion of residency.

By nature humans are suspicious of change and resistant to innovations. In the 90s we will experience startling advances in medical care and technology, far surpassing anything we have seen in our lifetime. This will be an exciting time in the health delivery system and an extraordinary time to be a physician.

In closing, we must pound away at the government to be more cost effective. We must work harder to make doctors, nurses, hospitals, nursing homes, payers and allied health personnel stronger and more effective allies. We must find more ways or better ways to inform the public and make patients our allies. Finally, we must reignite the fire that existed within us when we chose to become physicians, for the task ahead will not be easy.

Medicine is entering into an era of profound change. It is our responsibility to be leaders when decisions are being made that impact our patients or profession. If we do this, we can look back with tremendous pride and fulfillment and enter into a generation of men and women who will be proud to be called doctor.

Preston P. Nunnelley, MD
KMA President

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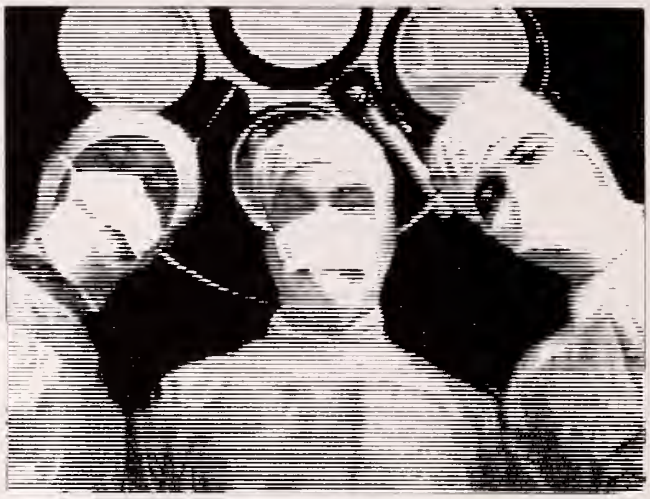

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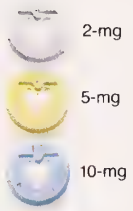

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Health Access America: An Update

A report by Alternate Delegate Robert R. Goodin, MD

Health Access America suggests an approach to the two most critical problems facing the American health care system—access to care and rising costs.

Among the large number of reports from the board and councils of the AMA and some 300 resolutions presented to the AMA House of Delegates at the annual meeting in Chicago, June 24-28, a very large amount of time was devoted to Health Access America. Following the I-89 meeting and in response to house resolutions, the AMA developed Health Access America, a proposal which integrates AMA policies into an address of the strengths and weaknesses of the US health care system. The proposal hopes to build on the many strengths of our health care system, address its weaknesses, and share with the public a positive pro-active health care program. This proposal is the product of extensive work and has been approved by the AMA Councils on Legislation and Medical Service along with the Board of Trustees, and was strongly endorsed by your House of Delegates at the recent annual meeting.

Health Access America suggests an approach to the two most critical problems facing the American health care system—access to care and rising costs. Despite national spending of some $600 billion, nearly 12% of the gross national product, on health care each year, 33 million Americans do not have access to affordable health care insurance for themselves and their families. These people obviously have less access to health care, and it is estimated that some 80 billion would be needed in additional revenues to provide this care. These people are often employed (70%), do not qualify for Medicaid, and simply can't afford health insurance. It is not at all certain that society is willing to pay for high quality care to all our citizens. We, as physicians, must be committed to help all of the people of this country receive high quality health care, and I believe should consider this a basic right. Health Access America is your 16-point proposal to address the many issues facing health care delivery in this country in an achievable manner.

In constructing this document, consisting of 16 major points, the AMA has considered a number of fundamental principles that should guide any discussion on improving the US health care system.

1. Improvements in the American health care system should preserve the strengths of our current system.
2. Affordable coverage for appropriate health care should be available to all Americans, regardless of income.
3. Particular efforts are needed to assure continued access by the elderly to affordable health care services.
4. Health care services should be delivered with high quality at appropriate costs.
5. Patients should be free to determine from whom and in what manner they choose to have health care benefits delivered.
6. All physicians should be committed to the highest ethical standards in the delivery of care to patients.

Most of our readers have read or heard the 16 points in the Health Access America proposal, and I will not repeat them here, but rather emphasize several issues receiving the most attention at the annual meeting. Obviously this proposal will be an ongoing and dynamic document with full implementation likely to require several years.

Before we can be certain what health care costs are appropriate, we must first address the issues responsible for the rapid rise in US health care costs, and also define clearly what a minimum benefit package should consist of. It is a consensus feeling that the vast majority of the increase in costs are attributable to the following:

- increased aging of the American population
- new technology
- federal and state regulations on physicians and hospitals
- professional liability insurance costs and defensive medicine
- administrative waste in health care delivery

When we consider the impact of these factors, we find that physicians have little control over several fea-

tures, but that we can impact on many of these and certainly can promote society to address still even other factors. For example, it is estimated that up to 22% of health care expenditures in this country are spent in administrative costs, and yet most experts would agree that 5% administrative costs should be sufficient. Correcting this "waste" alone in administration could result in savings of up to $100 billion annually.

. . . It is estimated that up to 22% of health care expenditures in this country are spent in administrative costs, and yet most experts would agree that 5% administrative cost should be sufficient.

A second major issue to address was the definition of a minimum benefits package for the uninsured. The house accepted a package presented by the Board of Trustees that is considered affordable. Today in the United States, the average cost per insured person for health insurance is $26,000 per year. The proposed minimum benefits package would cost $1700 per year and would still provide essential medical services. It should be noted that of hospitalized patients in the United States today, 53% are Medicare/Medicaid, 10% to 15% are uninsured, and 35% have private health insurance. Needless to say, this leads to a major problem in cost shifting and unfair pricing to the private pay patients.

Clearly the most important issue in Health Access America is, How do we pay for it? Obviously we must either develop new revenues, shift current revenues into health care, and/or improve the efficiency of health care delivery. The ultimate solution will obviously be a combination of approaches such as the following incorporated into Health Access America:

- reduce administrative cost and paper work
- repeal or override state mandated benefit laws
- push for major Medicare and Medicaid reforms
- professional liability reform
- professional practice parameters
- education of the public to healthier lifestyles and cost-conscious health care decisions
- mandated employer health insurance provision with appropriate tax credits
- state-level risk pools for hard to insure patients
- innovative changes in both tax laws and insurance underwriting

Isn't it ironic that while we in America are talking of a nationalized health care system, at the same time the British are privatizing their system . . .

Health Access America makes sense because it speaks to insuring all Americans, to cutting bureaucratic waste, to assuring quality, and to seeking solutions to the liability crisis. It is concrete and achievable and not just a series of vague principles and recitation of problems we all know exist. It is finally a proactive stance that places we physicians exactly where we should be, and that is clearly as advocates for high quality, affordable health care for all Americans.

Many are calling for a uniform national system of health care, possibly structured after the Canadian or British health care systems. Do we want to convert medicine to a public utility as many politicians and the health care financing administration may suggest? How much do you trust our government to do things simply or fairly? Do we really believe that our present onerous requirements and mandates through Medicare would improve with a national health insurance program?

If we can answer the above questions with a resounding *No*, then it is high time that we all do our part with our time and our resources to promote Health Access America and do our very best to keep the practice of medicine the greatest profession there is and not a trade. Isn't it ironic that while we in America are talking of a nationalized health care system, at the same time the British are privatizing their system—and for the same reason, to save money!

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1. Data on file, G.D. Searle & Co. **2.** 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.

BRIEF SUMMARY

Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

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Group C Streptococcal Meningitis With Favorable Recovery
A Case Report

Melissa Cheeseman, MD; Claude Genain, MD; Charles D. Smith, MD

Group C beta-hemolytic Streptococcus, *though an uncommon cause of meningitis in adults, often leads to the demise of the patient or a prolonged hospital course, usually with residual neurologic impairment. We report a case of group C streptococcal meningitis in a previously healthy young adult, with rapid and complete recovery following early initiation of IV penicillin therapy.*

Drs Smith and Genain are with the Department of Neurology at the University of Kentucky School of Medicine, 800 Rose St, Lexington, KY 40536.

Although commonly a pathogen in animals, group C *Streptococcus* rarely infects humans. When this occurs, the result is frequently one of high morbidity and mortality.[1-7] Death of the patient, or slow response to antimicrobial therapy with significant neurologic sequelae, is the rule in reports of Group C streptococcal meningitis in adults. We encountered a case in a previously healthy young adult, in whom antibiotic therapy was initiated immediately, with evidence of recovery noted within 24 hours of admission.

Case Report

A 24-year-old Hispanic male, employed at a local horse farm, was in his normal state of excellent health until 1 day prior to hospital admission, when he developed a progressively more intense bifrontal headache associated with fever, chills, nausea, and vomiting. On examination in the emergency room of another hospital, he was delirious and febrile (38.3°C) with meningismus and an erythematous oropharynx, but without focal neurologic findings. Blood counts were obtained and he was given 3 million units of penicillin intravenously (IV) before transfer to our hospital. Upon arrival, 30 hours after onset of his symptoms, he was nauseated and vomiting with marked nuchal rigidity, confusion, and disorientation. He had bilateral Babinski signs but no focal deficit or papilledema. No skin rash or lymph nodes were found. His peripheral white blood count was 16,700 μL (with 81% segmented neurophils and 12% bands); his blood sugar was 132 mg/dl. A lumbar puncture yielded yellow purulent cerebrospinal fluid (CSF), with glucose 35 mg/dl, protein 294 mg/dl, WBC 11,000 μL (97%) polymorphonuclear cells) and gram positive diplococci. Culture of CSF as well as the blood cultures obtained before transfer grew group C beta hemolytic *Streptococcus* belonging to the species *zooepidemicus*.

The patient was treated with IV penicillin, 3 million units every 3 hours, changed after 24 hours to 4 million units IV every 4 hours and continued for 14 days. The patient was afebrile, alert and oriented within 24 hours of admission. He manifested no neurologic sequelae at discharge. Subsequent follow-up, including formal audiometry, failed to reveal sequelae from meningitis.

Comment

Group C streptococci are infrequent pathogens in man, causing only occasional cases of bacterial endocarditis, cellulitis, bacteremia, bronchopneumonia and meningitis. Often, such infections occur in patients with underlying or complicating illness and carry a severe prognosis.[8] Commonly (as in our patient), no portal of entry is found. Our patient is the first reported with group C *Streptococcus* meningitis in Kentucky.

The most consistent source of human disease has been contaminated unpasteurized milk or milk products.[9] Sixteen cases of group C *Streptococcus* infection including one case of meningitis, occured in New Mexico in 1983, linked to the ingestion of "queso blanco," a homemade white cheese.[7] A common source outbreak related to the drinking of raw milk has also been

reported; meningitis accounted for 3 of these 12 cases.[6] Mohr's patient was a farmhand who drank raw milk.[5] Our patient denied exposure to unpasteurized milk or milk products.

The species of Group C beta-hemolytic streptococci known as *Streptococcus zooepidemicus* is a common commensal in the upper respiratory tract of horses.[10] Low et al were able to culture *S. zooepidemicus* from the CSF of their patient with meningitis, as well as from the pharynx of the patient's pet horse.[5] Our patient worked closely with horses on a thoroughbred farm. How the organism gains access to CSF is unclear.

Poor prognosis of group C streptococcal meningitis is most significant at the extremes of age, ie, in infants[11, 12] or in debilitated, adult hosts.[1, 6] Among patients who survive, response to treatment is slow and neurologic sequelae such as personality change[4] and persistent vestibulocochlear deficits[5] are frequent. Our case demonstrated rapid improvement and complete recovery with no detectable sequelae at follow-up visits. In addition, it is our impression that rapid recovery is facilitated by immediate presumptive antimicrobial therapy.

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Wegener's Granulomatosis Presenting As Subglottic Stenosis

Cathleen J. Morris, MD; Ryland P. Byrd, MD; Thomas M. Roy, MD

One of the rarest diseases associated with upper airway obstruction in adults is subglottic stenosis from the necrotizing vasculitis of Wegener's granulomatosis. Early recognition and treatment of this potentially fatal syndrome is necessary to insure long-term survival.

From the Division of Internal Medicine, University of Louisville School of Medicine, 550 S Jackson St ACB-3, Louisville, KY 40202.

Introduction

Wegener's granulomatosis, a syndrome of unknown etiology, most often presents as a combination of sinusitis, pulmonary infiltrates, and glomerulonephritis. Necrotizing vasculitis has usually affected the small arteries and veins of several organs by the time of diagnosis. Only rarely does this disorder present with single site involvement. Particularly uncommon is the early primary involvement of the tracheolarynx.[1] Nevertheless, obstructive upper airway symptoms have been the initial manifestation of Wegener's granulomatosis in a limited number of patients.

We present a patient who presented with stridor and was treated for hyper-reactive airways disease. She was subsequently found to have subglottic stenosis from Wegener's granulomatosis. Our report is intended to draw attention to this rare but treatable cause of upper airway obstruction and provide a review of the literature regarding this unusual presentation.

Case Report

J.M., a 17-year-old white female, was hospitalized for treatment of severe stridor and low grade fever. Initially thought to have tracheobronchitis, she was treated with intravenous cefuroxime, intravenous steriods, and inhaled humidified racemic epinephrine. She improved and was discharged, only to experience recurrence of symptoms one week later while on tapering doses of oral prednisone.

When reevaluated, she was afebrile. On chest radiograph, a small infiltrate was now evident in the right upper lobe. An allergy evaluation suggested a clinical diagnosis of left maxillary sinusitis. A culture was taken from the left maxillary sinus but was unremarkable. She underwent indirect laryngoscopic evaluation of the larynx and glottis. Diffuse erythema was seen, but no evidence of stenosis, foreign bodies, or masses could be documented. No biopsies were performed. When oral antibiotics, prednisone, and bronchodilators effected only minimal improvement, the provisional diagnosis was viral tracheobronchitis with hyper-reactive airways.

The patient was reevaluated weekly in an outpatient setting. A repeat chest radiograph was obtained 6 weeks after her initial presentation and showed multiple small infiltrates bilaterally. Sinus films showed opaque maxillary sinuses. Her hemoglobin had decreased from 13.5 gm % to 11.7 gm %. Her white blood cell count was 10,500/mm3 with a normal differential. Her erythrocyte sedimentation rate was increased to 60 mm/hr (Wintrobe). A urinalysis contained 20-30 white blood cells, 80-90 red blood cells, and 2+ proteinuria. Two to three granular casts were present per high-powered field. She was not having menses at the time the urinalysis was performed. Studies for circulating immune complexes, ANA, serum complement, and anti-DNA were all negative. Serum creatinine was 1.2 and her BUN was 21.

The diagnosis of Wegener's granulomatosis was strongly considered and she agreed to a nasal biopsy. The biopsy was taken from the left tur-

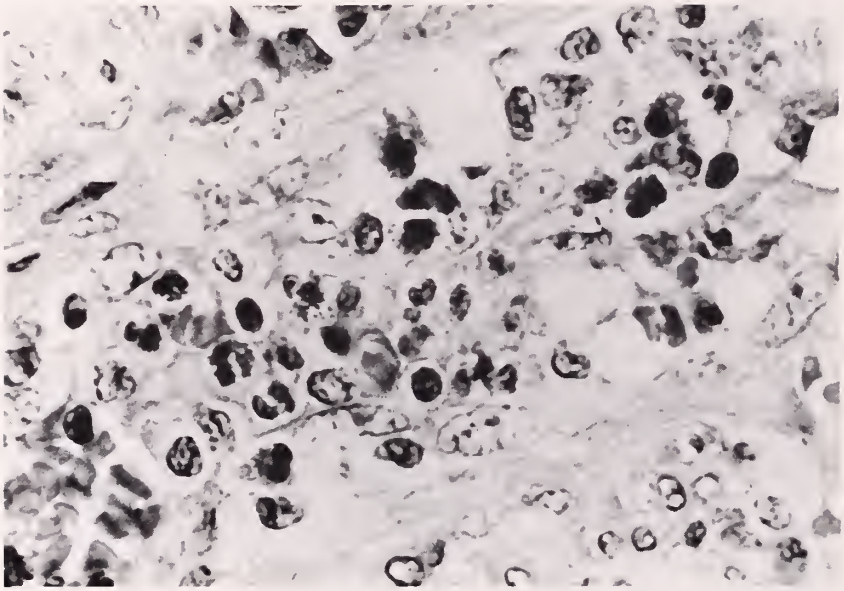

Fig 1

binate and contained necrotizing granulomas with prominent multinucleated giant cells. (Fig 1). She was started on cyclophosphamide 50 mg tid and prednisone 60 mg every morning.

It was the intention of her physician to continue the cyclophosphamide at 50 mg tid for at least 1 year in accordance with the recommendations of the National Institutes of Health.[2] Her prednisone, however, was tapered to 20 mg each day after 2 months of treatment. At this point, she again developed severe stridor. A neck film showed marked narrowing of the subglottic area. Direct laryngoscopy confirmed marked subglottic stenosis.

Recrudescence of Wegener's was suspected. Tracheotomy and excision of the subglottic lesion were performed. The pathologic examination of the subglottic tissue showed nonspecific inflammation, but no granulomas were seen. All cultures and special stains were negative. The patient did well with the tracheotomy and completed 13 months of cyclophosphamide and prednisone. She currently remains in remission and is maintained on Bactrim-DS each day. She has been successfully decannulated and is attending college classes.

Discussion

This patient's presentation was unusual in that she developed Wegener's granulomatosis with primary laryngeal involvement marked by severe respiratory stridor. Wegener's granulomatosis is typically a diffuse multisystem disease with the classic triad consisting of granulomatous lesions in the upper and lower respiratory tract, generalized vasculitis involving arteries and veins, and focal necrotizing glomerulonephritis.[3] Involvement of the larynx and trachea is not an uncommon late finding and most often manifests as subglottic circumferential narrowing usually without involvement of the vocal cords or distal trachea.[1] A review of 214 patients with Wegener's granulomatosis demonstrated eventual laryngeal involvement in 8.5%.[1] In the majority of cases, laryngeal disease has occurred late in the course and has only rarely been reported as the initial manifestation of disease.[4] Our review of the literature shows only nine previously reported patients who presented with primary laryngeal involvement. Our case report documents the tenth reported patient whose initial symptoms were of upper airway obstruction. (Table).

The age and presentation of our patient support previous studies that have shown striking differences in the presentation and disease involvement in adolescents and young adults when compared to older age groups.[5] While both groups have a similar incidence of upper respiratory, lung, and kidney involvement, there appears to be an increased incidence of oral cavity, laryngeal, and CNS involvement in adolescents and young adults.[5] Investigators have reported a 30% incidence of laryngeal involvement in patients less than 25 years of age compared to only a 10% incidence in those over the age of 25.[5]

Patients presenting with stridor and tracheal narrowing as the initial manifestation of Wegener's granulomatosis pose a diagnostic challenge and, like our patient, may be initially misdiagnosed. Lateral neck films are helpful and usually display the area of narrowing.[4] The differential diagnosis is considerable and includes tuberculosis, histoplasmosis, blastomycosis, syphilis, sarcoidosis, amyloidosis, malignant tumors, relapsing polychondritis, and Wegener's granulomatosis.[6]

Interestingly, biopsy specimens from the upper respiratory tract lesion are rarely diagnostic and typically show evidence of acute and chronic inflammation with necrosis.[4] Granulomas may be present but evidence of vasculitis is rarely found. Its absence should not preclude the diagnosis of Wegener's granulomatosis if sufficient clinical findings are present.[4] A recently available labo-

Table 1. Potients Presenting With Upper Airwoy Symptoms From Subglottic Stenosis Due to Wegener's Granulomotosis.

Age/Sex	Presenting Symptoms	Laryngeal Biopsy	Lote Monifestotions	Treatment	Immediote Outcome
18/M	Hoorseness Dyspneo	Granulomo	Soddle nose Sinusitis Glomerulonephritis	Corticosteroids	Died
17/F	Hoorseness Stridor	Not Avoiloble	Skin vasculitis Glomerulonephritis	None stoted	Trocheostomy Diolysis — Remission
55/M	Hoorseness	Gronulomo	Glomerulonephritis	Corticosteroids Cyclophosphomide Azothioprine	Trocheostomy Tronsient Renal Foilure Remission
39/F	Hoorseness Stridor	Gronulomo Inflammotion	Glomerulonephritis Lung infiltrotes	Corticosteroids Rodiotion	Trocheostomy Renol Foilure — Died
14/F	Hoorseness	Gronulomo Inflommotion	Hemoturio Skin Ulcers	Corticosteroids	Trocheostomy — Remission
51/M	Dyspneo	Inflommotion	Glomerulonephritis Skin purpuro	Corticosteroids Cyclophosphomide	Trocheostomy — Remission Renol Insufficiency
52/M	Hoorseness	Gronulomo Necrosis	None stoted	Corticosteroids	Died - recurrent tracheol obstruction
26/M	Hoorseness Stridor	Gronulomo Vosculitis	Not Avoiloble	Corticosteroids Cyclophosphamide	Trocheostomy —Remission
24/F	Dyspneo	Inflommotion	Glomerulonephritis Lung infiltrates	Cyclophosphomide	End-End Trocheol Anostomosis Permonent trocheostomy Remission
17/F**	Stridor Fever	Inflommotion	Sinusitis Lung infiltrotes Glomerulonephritis	Corticosteroids Cyclophosphomide TMP/SMX	Trocheostomy — Remission

* Chort is modified from report by Hellmonn.[4]
** Current cose report.

ratory test which should be helpful in establishing the diagnosis of Wegener's granulomatosis is the anti-neutrophil cytoplasm antibody assay (ANCA). These antibodies are directed against myeloid specific lysosomal enzymes which have been found in patients with necrotizing vasculitis as well as in patients with idiopathic necrotizing and crescentic glomerulonephritis.[7] Specificity in Wegener's granulomatosis has been reported to be 98% by this ELISA method. The sensitivity is 93% for active generalized disease and 40% when the disease is in full remission. The sensitivity decreases if the disease is localized. The levels of ANCA parallel disease activity.[8] This observation may be helpful in following a patient's response to treatment and in distinguishing relapse from other processes such as infection.[8]

The majority of patients who have developed subglottic stenosis have required tracheostomy. Death occurred in three of the previously reported patients. One patient died from recurrent tracheal obstruction 54 months after diagnosis. Two patients developed progressive renal failure and one required hemodialysis. Surgical end-to-end anastomosis of the trachea with creation of permanent tracheostomy was performed in one case. Importantly, of the deaths reported, none of the patients were treated with cyclophosphamide. Our patient achieved remission of her disease as did all other patients treated with this agent. This observation has led investigators to propose that early use of cyclophosphamide improves the outcome of disease in those patients presenting with early primary laryngeal involvement.[4]

Treatment of patients with the classic triad of Wegener's granulomatosis with cyclophosphamide has been credited with a greater than 90% remission rate if treatment is continued for at least 1 year following the disappearance of active disease.[2] The addition of corticosteroids is advocated for patients with severe disease and can be tapered once the disease is under control.[2]

Investigators have also reported improvement in disease activity with the use of trimethoprim/sulfamethoxazole (TMP/SMX), ie, Bactrim or Septra.[9] In a few cases, TMP/SMX has been used alone as initial therapy and has been thought to have induced remission. Improvement has also been noted when TMP/SMX was added to conventional regimens.[9] Theories regarding the success of this therapy include the exciting possibility that Wegener's granulomatosis may be the result of infection which initiates an abnormal immune response in the host causing disease. The TMP/SMX may eliminate or suppress the infecting organism. However, TMP/SMX also acts as a folic acid antagonist and this action has been postulated as a possible favorable influence on disease suppression.[9] At this time there is insufficient evidence to recommend TMP/SMX as exclusive initial therapy, but this compound should be considered as a possible adjunct to conventional regimens and as a medication to maintain remission.

In conclusion, we hope that our report will heighten the clinician's awareness of the potential for Wegener's granulomatosis to present with upper airway symptoms and consider this entity in adolescent and adult patients with stridor.

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Rural Medicine

Loman C. Trover, MD

This is a presentation made by Dr Trover to the students and faculty of the University of Louisville School of Medicine during his 3 days of activities as the School of Medicine Alumni Fellow.

It is always a pleasure to be with young physicians. It carries me back some 50 years to when I sat in the audience and heard Dr Arnold Griswald introduce a physician from out in the state.

This rural practitioner was Dr C.C. Howard of Glasgow, Kentucky. Dr Howard not only was an able physician and a fine gentleman, but he was also the father of the Kentucky Rural Medical Scholarship Fund. I thought for many years that I had received the first loan from the Fund, and it was just recently that I became aware that mine was the second grant. First or second, it was greatly appreciated when it was awarded.

Since I am discussing rural medicine today I feel that a brief review of its history is in order.

As a medical student some 50 years ago, I participated in many discussions of what role we would play as physicians. Many students at that time expressed an interest in "general practice." I found that these students were in one of three categories:

1. Students who had a deep interest in general practice and fully intended to make it a professional career in a rural setting. By and large, these students followed through with their objective.

2. Students who professed an interest in general practice because their family or a muchly admired role model physician wanted them to return to their hometown. Even though the incentive for this reason was great, a number changed their minds and eventually chose another type of practice.

3. Students who very openly admitted that they intended to use a rural general practice as a means of making enough money to pay off their debts and allow them to specialize.

But even so, out of these categories of students came a noticeable flow of physicians into rural areas.

It was soon noticed, however, that a decided element of attrition was taking place. Older physicians were not being replaced by younger ones. The process was continuous and seemingly inexorable. Soon one, two or even three thousand population towns were without physicians. In the more remote areas whole counties did not have even one physician. Bitter complaints began to be heard throughout the rural sections of our country. Legislators, both state and national, listened and made efforts to solve the problem. Many laws were passed — many programs formed — and much money was appropriated, but satisfactory solutions remained elusive.

It was and still is difficult for our legislators to recognize that you can't drop a program "in from above." They are dealing with people's rights, and as such, the people have to be a part of the solution.

In so many of the legislative programs, as the money dried up so did the programs. It began to appear that the general practitioner was heading fast to extinction. Then a few dedicated, far-

It has been my premise for many years that there must be a close linkage between education and health care delivery if we are to have a sufficiently equitable distribution of physicians and other highly trained medical personnel to allow a regional complex to develop.

sighted people initiated and implemented the Family Practice Boards. This increased the training period of the younger physician but also gave him a professional status comparable to his peer specialists. This was met with initial enthusiasm and there was a resurgence of interest in Family Practice.

At about this time, we began to see the appearance of another phenomenon. Rural people were becoming less and less isolated due to great advances in communication and transportation. They were better able to visualize health care as it was rendered to the urban populations. The rural populations still put great faith in their family physician, but they felt they deserved a full range

of available and accessible health care.

How could such services be furnished low density populations? I have always felt that medical centers could be placed anywhere, if you had the following three prerequisites: (1) Adequate patient demand; (2) highly trained professional personnel to provide the services; and (3) acceptable buildings and sophisticated equipment to support the professional personnel.

Many of us who have experienced the delivery of health care in rural low density population situations came to the forced realization that practitioners can no longer become isolated to a solitary practice, if the availability of comprehensive health care is to be obtained. Unless we allow our minds and heart to recognize and to reach out toward a broad objective, it will never be obtained.

Let us start with the basic objective that people in rural settings want and deserve as broad, as comprehensive, as easily accessible a health delivery system as the people in our urban centers. We must *recognize* the fact that people in rural areas are no longer isolated. They are no longer unknowledgeable of the many advances of medical science, and of the many things that can be done to alleviate or correct their health deficiencies. They no longer feel that a single physician, even though he is possessed of great capabilities and a splendid bedside manner, can serve their full needs; and no longer do they wish to be sent at rather frequent intervals hundreds of miles to receive the benefit of medical expertise that should be at a closer and more accessible facility.

The advent of many payment mechanisms including Medicare, Medicaid, and other third party payors has also tended to focus attention rather sharply on the rural areas and has pinpointed the great deficiency or the actual lack of professional health care in many of these areas. Rural people have the feeling that they have been disenfranchised because they are unable to constructively participate in the programs which are supposedly nationwide in scope.

What then does the future hold for our rural health care delivery system? What can be done by physicians and other leaders to achieve a solution to these problems? One of the first things that we must consider is an analysis of the overall efficiency of the system as it exists, recognizing that more efficiency could be obtained through a more orderly or better organized approach. In other words, structure the rural health care delivery system to the point that it would be more efficient in its output both as to quantity and quality.

There can be no doubt that one of the greatest problems that the regional care delivery system faces is that of obtaining sufficient and adequately trained personnel.

With this thought in mind, I would like to consider what has been termed "the regionalization concept of health care delivery." In this concept we assume that there would be acceptance of centralized responsibility to make available to the people in a defined region a comprehensive health care delivery system utilizing as much scientific and delivery sophistication as possible. It follows, therefore, that there must be a strong coordinating entity that would be willing to and have the capacity of assuming this centralized responsibility. It would seek out and document areas in which services are lacking and set priorities on correcting these deficiencies.

As the evolutionary process gained momentum, continuous growth and refinement would bring about the participation of many organizations not ordinarily felt to be a part of the health care system. As a result, a regional effort would evolve which had as its beginning a local nidus that had subtly grown by spreading outward to incorporate all needed organizations and facilities. In so growing from within the region, utilizing first its own resources and then calling upon other resources as their need was pinpointed, the local element would feel it was handling its own problems. The controversy which is so often generated when ideas, no matter how sound, are brought

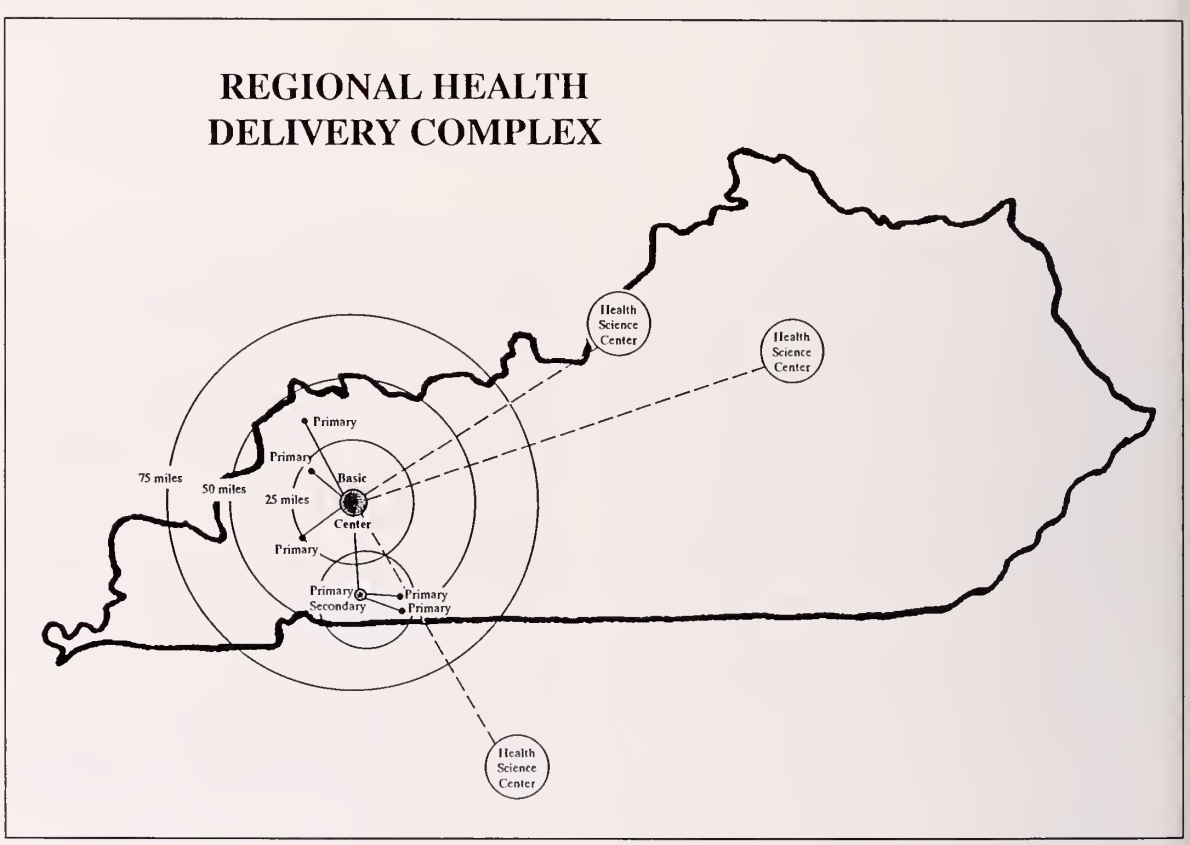


Fig 1

in from above is circumvented to a great extent.

We must never lose sight of the fact that no matter how basically sound or well merited the idea, satisfactory implementation can only come from the active interest and desires of the participating people. Sound ideas can be killed just as completely by lethargy as by overt antagonistic action.

Who should be this coordinating force? Who should assume this basic responsibility?
Let us explore several proposals —

1. The American Hospital Association has indicated that it feels that hospitals should assume this responsibility. It is a fact that in rural sections of the country hospitals are usually the place in which the organizational structure is present to allow it to assume a leadership role in the health care endeavors of the region. Along with its professional staff, it can initiate long-range planning and implement new endeavors. There can be no doubt that the hospital in many rural sections of our country is the hub of health care activities.
2. The area health education center concept as projected first by the Carnegie Commission in 1970 also carried as one of the basic motivations the assumption of the responsibility to see that elements of the health care delivery system be made readily available to a selected segment of people.
3. Well-organized group practices in many instances have assumed a great deal of this responsibility and in a number of rural sections have been successful in changing the health care available to a rather dramatic degree. In fact, many of the group practices offer a very fertile ground for the staff model health maintenance organization concept in that the basic organizational structure is already present.
4. The greatest potential can be achieved by group practices and hospital facilities coming together under one entity — a nonprofit foundation. This is the format of the Mayo Foundation which has been so successful through the years. By the physicians and the hospital being under one head and approaching their

growth objectives with one coordinated approach, the greatest growth and operational efficiency can be obtained. In the present day, and even more so in the future, it behooves physicians and hospitals to so structure themselves that the best broad-range health care delivery can be afforded the population in their catchment area in the most efficient manner.

It has been my premise for many years that there must be a close linkage between education and health care delivery if we are to have a sufficiently equitable distribution of physicians and other highly trained medical personnel to allow a regional complex to develop. It has been shown that physicians form rather definite affiliations for future practice during their training years. If they obtain some exposure to the regional practice of medicine during their training, it must be assumed that when the time comes to choose a place to practice due consideration will be given to regional centers.

Not only must regional centers have physician personnel, but as they develop they must have all the personnel necessary to make up a sophisticated system ranging from nurses aides to medical secretaries, nurses, technicians, physician assistants, and other ancillary personnel. There can be no doubt that one of the greatest problems that the regional health care delivery system faces is that of obtaining sufficient and adequately trained personnel.

Figure 1 offers a conceptualization of a regional health care delivery set up in a rural area. As you will note, this schematic presentation is composed of first, a region and secondly, within the region, a basic center with multiple primary centers radiating from the basic center. You will also note that the basic center is affiliated with a health science center — either single or multiple as the circumstances would warrant.

The basic center would of necessity be the center in which the health care delivery system was the most advanced, and which had the

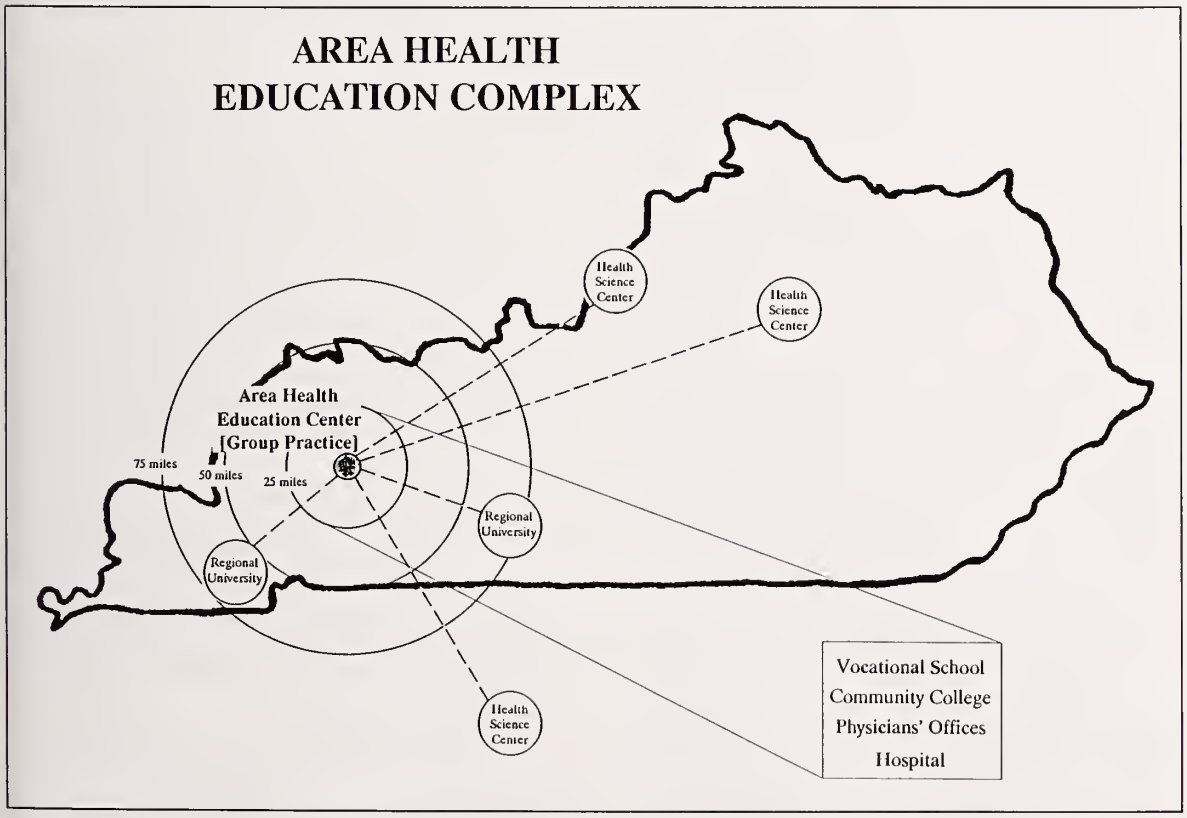


Fig 2

Table 1. Madisonville Health Occupations School Graduates, 1971-1988

Total Graduates	1,887
Radiologic Technologists	187
Licensed Practical Nurses	838
Medical Laboratory Technicians	130
Surgical Technicians	143
Medical Secretaries	151
Respiratory Therapists	154
Others (Medical Office and Ward Clerks, Biomedical Technicians, Paramedics)	284

Table 2. Madisonville Community College Health Professions Student Enrollment Associate Degree Program, 1990

Nursing	136
Radiologic Technology	48
Respiratory Therapy	23
Biomedical Technology	19

professional personnel and the physical facilities to allow as broad a range of services as possible. This would usually be the area of relatively high population density. The largest most comprehensive hospital as well as other ancillary facilities would be located in this area.

The primary centers would be located in smaller population densities usually serving a moderately large surrounding area. They would be affiliated with the basic center either formally or informally, in an organization setup that would allow the patients to flow freely from the primary care to the secondary-tertiary care area without undue impedance, and with a rapport that would allow a "transfer" of the patient rather than a "referral."

The physicians who staff the primary centers should be an integral part of the broad organizational structure and be quite active in administrative functions. If adequate primary physician coverage was already present in these areas they should be utilized in the organizational coordination. If sufficient physician personnel was not present efforts should be made to staff these primary areas with the basic center being just as interested in bringing about this staffing as would the primary care centers.

At the other end of the spectrum is the health science center which would have the capabilities of very broad health care delivery as well as educational expertise. Here again the organizational structure should be such that it would allow the transfer rather than the referral of a patient, with the health science center recognizing the work done in the basic center and therefore duplicating as little of the work as possible. For this to come about, there must be a very close rapport between the health science center and the basic center with uniform standards of quality of care that would be readily recognized by both facilities. The extent of the work done in the basic center would be dependent upon the range of coverage that the center was qualified to produce. There would be a sizeable variance between basic centers.

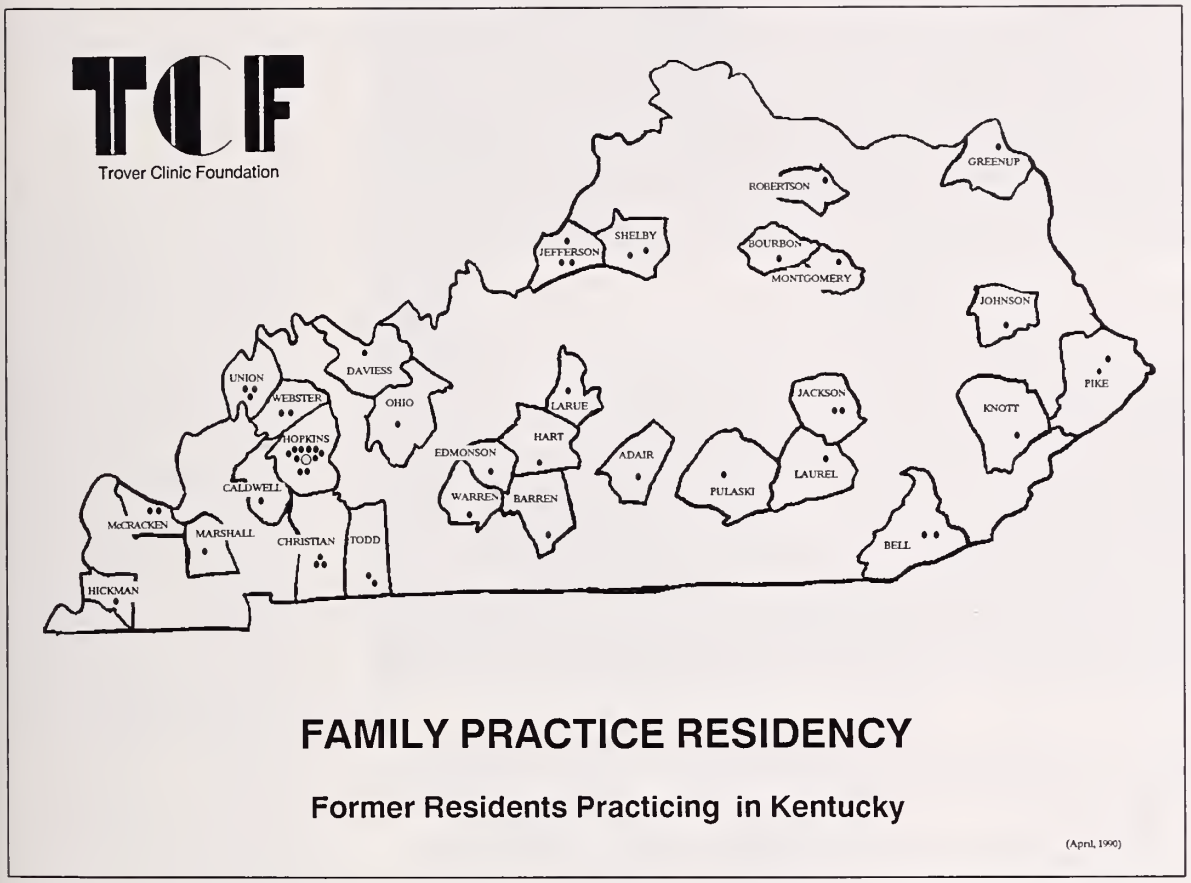
Figure 2 depicts the area health education center. In this concept, we would have a centralized area center with as many coordinative components as is available within the regional area. These components would be composed of hospitals, physicians, community colleges, vocational schools, and regional universities if present.

The area center would be affiliated with either single or multiple health science centers. Residence programs such as Family Practice Residencies would be primary to the basic center, but most of the physician exposure would be through rotation of students and residents from the health science centers.

The educational complex would utilize its training facilities to its full capacity, ranging from the vocational or 1 year level through the associate degree or the 2 year level of training. Professional personnel receiving training at a higher level would have to be on a rotation basis from the health science centers or possibly from other universities out of the region. For this type of system to work adequately and to its fullest potential, the ladder concept of educational training would be highly desirable. This would allow the horizontal and vertical progression of the students with as little loss of educational credit as possible.

It has been shown that personnel trained as technicians, associate degree nurses and so forth, have a tendency to stay in the area in which they are trained. This fact has a twofold function: (A) it allows for the staffing of regional programs; and (B) it also offers multiple opportunities for people in the area to train for gainful and productive employment.

Table 1 lists the Madisonville Health Occupations School Graduates and Table 2 the students enrolled in the Madisonville Community College Health Professions Associate Degree Program in 1990.

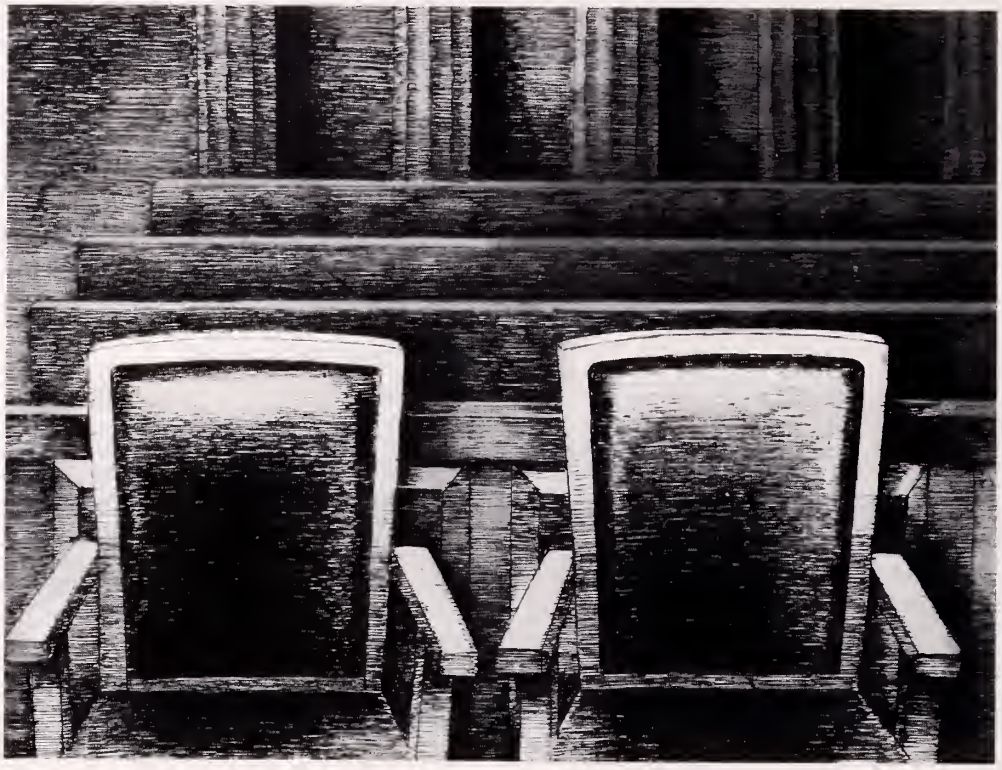


Map 1

The importance of these two institutions cannot be overemphasized. Both of these facilities train people from our own region and to a great extent the graduates remain in the same region. As is noted, a number of the categories overlap. X-ray technicians get their full certificate training at the vocational school, but with added didactic training at the Madisonville Community College they receive an Associate Degree in Applied Science, which furnishes them a 2 year academic educational base. There would have been no way that our area could have supported a 400-bed hospital and a 100-plus physician multi-specialty group practice without the trainees from these two institutions.

Map 1 identifies the graduates of the Trover Clinic Foundation Family Practice Residency practicing in Kentucky. This map shows placement of our family practice residency graduates in the Commonwealth of Kentucky. It can be seen that they are scattered fairly well throughout the state and to a very great extent in rural areas. Since its beginning in 1972, 91% of the graduates of this program have remained in Family Practice (or related primary care). Eighty-five percent of the graduates have remained in Kentucky. Eighty-seven percent of the graduates are practicing in a rural area.

In closing, it is my belief that quality health care should be available to all of Kentucky's citizens through a series of networks and regional sites, and not just in a few large cities.



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The Fun Days Are Gone

'Small wonder the fun is gone. Take the government money and take the government control. Accept the insurance policy restrictions and accept the increased risk to the patient. Unfortunately, the government and the insurance companies are faceless monoliths that defy identification.'

It seems as if everything I know or learn, I learn in the doctors' lounge. It also depends upon the hospital lounge that I attend as to the subject matter. Topics vary from the best new restaurant, make of car to buy, rookie guards in the NBA, IRAs and mutual funds, who made the bomb runs to Ploesti and Schweinfurt, and posh vacation spots. Rarely is medicine discussed.

So I'm sitting there one morning at the crowded main table and the doctors are having a desultory conversation about everything and about nothing. Then one of them says, "You know, the fun days are gone." With that remark heads turn up, doughnut bites stop in mid-air, plastic stirrers stop their swizzle, and newspapers are half folded and eyes peer over to see from whence came the comment. A common cord had been struck and all there had to agree, it isn't fun anymore. Medicine has changed from fun to a profession.

Patients haven't changed, or have they? Doctors haven't changed, or have we? Diseases haven't changed (except for AIDS), or have they? Treatment — yes, that has changed; for the better and for the more expensive. Every advance we make in diagnosis or in treatment costs more than before. Every life we prolong costs more because therapy and support costs more than death.

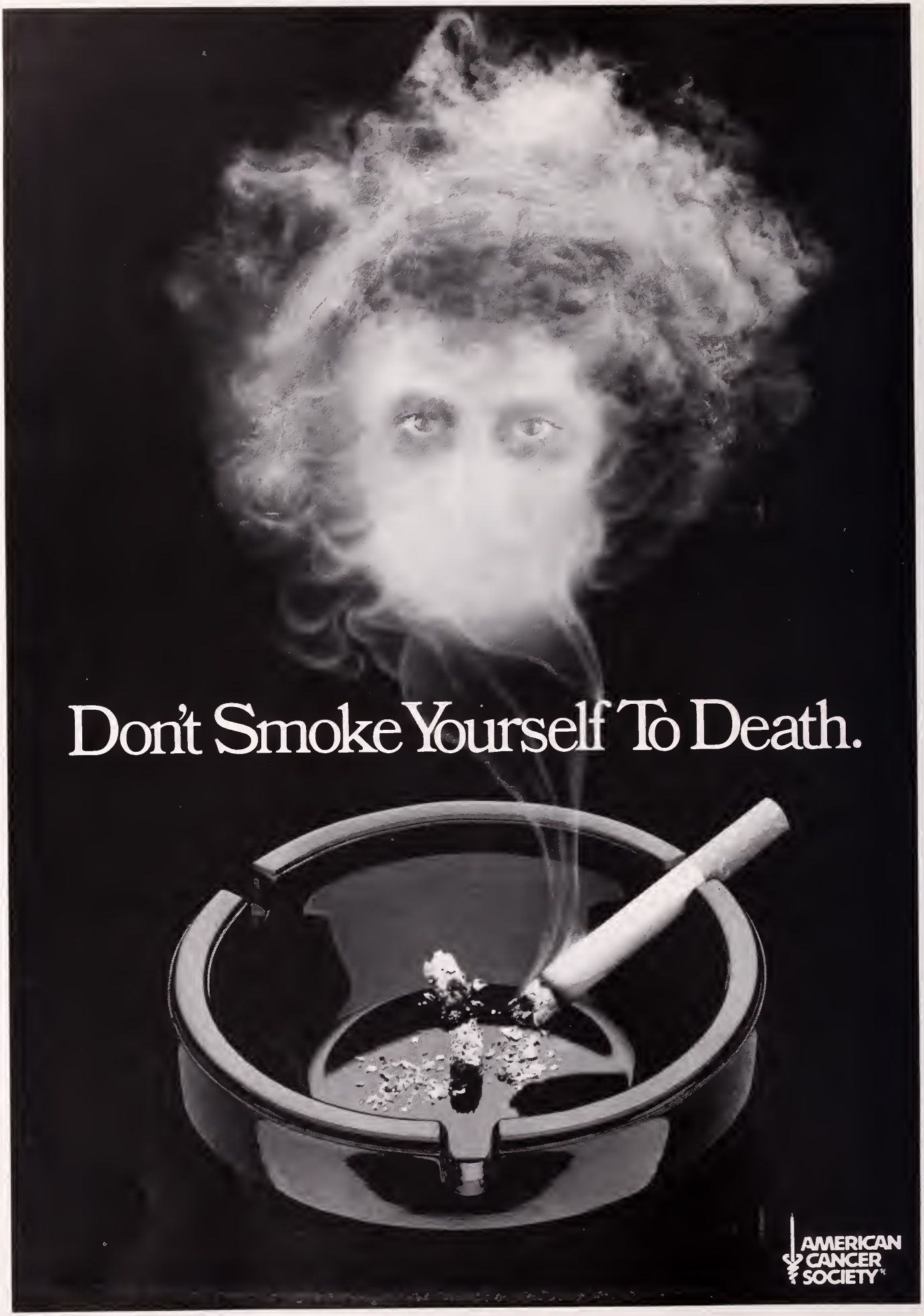
Today I offer no answers nor remedies. I offer only a comment on a comment. In February of this year a lead newspaper article on medicine was titled "Doctors and Patients — Traditional Relationship Growing More Adversarial." Then later in August another lead article was titled "Medicare: 25 and Ailing."

Small wonder the fun is gone. Take the government money and take the government control. Accept the insurance policy restrictions and accept the increased risk to the patient. Unfortunately, the government and the insurance companies are faceless monoliths that defy identification. The doctor has a name and a face and an address and a number. These facts and his practice habits and charges are all duly recorded on some plastic tape that can be called up in a millisecond. Heck, we can't even identify the person who chooses the DRG number on our charts. Then we have to attest that the information is correct. Whom do they come after in case of a dispute? the ephemeral shadow? or that face? You know who.

To paraphrase a famous French politician who said, "War is too important to be left to the general." It now seems medicine is too important to be left to the doctors. The fun days are gone.

Milton F. Miller, MD

This space contributed as a public service.



Students Keep Rolling Along!

'The suggestion I might make to all physicians and their spouses is "support." Medical students always remember the physician who helped them along the way both financially and emotionally. Remember?'

A few weeks ago I had the privilege of participating in orientation week for the incoming freshmen at the University of Louisville School of Medicine. As the President of the Auxiliary to the Kentucky Medical Association, I was asked to speak to the students and their spouses about the role of the Auxiliary and how the Auxiliary supports medical students and their spouses. The main purpose of my participation in this orientation week, however, was to assure students and their spouses that organized medicine, including the auxiliaries to the medical societies, wants to assist medical students early in their careers.

Throughout the day, in talking with these young people, I learned that their concerns and the concerns of their spouses are much the same as 40 years ago when I was the young spouse of a medical student. Then, as now, making the grade and finances were at the top of the list. One common theme, however, was a feeling of anticipation and anxiety. Perhaps today, though, there is greater concern that students and spouses share in managing the home and household chores. I feel that these anxieties have surfaced since this class of 1994 is 49% female and the homes have become sharing responsibilities.

The University of Louisville and the University of Kentucky medical schools have student representatives supported by the Auxiliary to the Kentucky Medical Association to help encourage students and spouses where needed.

We in the Auxiliary to the Kentucky Medical Association hope that we can encourage in every way the students at the University of Louisville and University of Kentucky medical schools.

'. . . Organized medicine, including the auxiliaries to the medical societies, wants to assist medical students early in their careers.'

As I told the freshman class, the Jefferson County Medical Society Auxiliary and the American Medical Association Auxiliary also offer their financial help through the monies made for the American Medical Association-Education and Research Foundation (AMA-ERF).

Approximately $42,000 was raised last year through AMA-ERF to be used by the two deans of our state medical schools for the student Financial Aid Fund and Excellence Fund. The Excellence Fund is to be used at the dean's discretion, and the Emergency Fund is to be used by students as it is needed for student emergencies.

The suggestion I might make to all physicians and their spouses is "support." Medical students always remember the physician who helped them along the way both financially and emotionally.

Remember?

Betty Schrodt
AKMA President

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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Preston P. Nunnelley, MD
KMA's President 1990-91

With the ease that comes from knowledge and experience, the newly elected leader of the Kentucky Medical Association fielded questions with an impressive store of knowledge, speaking at once with the acuity and insight he might use when addressing the House of Delegates, and with the warmth and sincerity he might use when chatting with close professional friends. Approachable, articulate, affable, adaptable, is but a brief description of this gentleman.

Preston P. Nunnelley, MD, a Lexington obstetrician and gynecologist, began his educational endeavors planning to become Preston P. Nunnelley, Civil Engineer. However, life took a new direction when at the end of his first year of college he married Lucille, his teenage sweetheart. He was 19, she was 18. Through ensuing changes, brought about by necessity, his future was determined.

"I started hanging around the hospital and got a job as an orderly working from 11 at night until 7 in the morning. I took the job for two reasons. Obviously, I needed the money to continue my education and support my wife, and although I loved engineering, I was beginning to have an interest in medicine. I gained a great deal of insight through my hospital work, seeing the doctors coming and going all hours of the night, and the excitement of the emergency room. I decided to go into medicine at that time. I switched my major from engineering to premed and have never looked back, nor regretted it."

This native of Mt. Vernon, "a town of about 1,000 in a county which has only about 14,000 people and had only one physician in the community when I was growing up," earned his undergraduate degree in 1964 from Eastern Kentucky University and completed his medical degree at the University of Kentucky College of Medicine in 1970, followed by a residency in obstetrics and gynecology at U of K from 1971-74.

Normally reserved, Dr Nunnelley becomes passionate, speaking of his chosen specialty. "Rotating through as a student, I developed a real enthusiasm for obstetrics, and a lot of people didn't share my enthusiasm because of the hours. But, I tell you, and this holds true today, there is nothing more rewarding than being with a family you have gotten to know and like and sharing in the birth process with them. It is just very exciting to me. I've always been interested in surgery and until just a month or so before I had to make a decision on internship and residency I was going exclusively surgery, but I just didn't want to give up the obstetrical part." He still does not want to give it up and continues to put in long hours in the very successful practice he began in Lexington in 1974.

'I have a personal goal for this year to develop a program that in some way will instill a positive attitude toward medicine so that more physicians are proud that they are physicians and will encourage their own children and others to enter medicine.'

Thoroughly committed to the care of his patients, Dr Nunnelley expresses concern for the future of obstetrics due to the effects of malpractice insurance. "The outlook is not as good as I would like. Burnout is very high in obstetrics. We can no longer really appreciate the joy of bringing a birth into this world for fear that something is not exactly right. Unfortunately, a lot of people are suspicious of doctors, and if we begin a relationship based on suspicion, how can it ever develop into anything good? The stress, particularly if one has been sued, and OBs are sued more than we like to even think about, is bringing about an early exodus. A lot of physicians are giving up their OB but continuing in gynecology for several more years, until retirement. This is regrettable because it is robbing young mothers of a population of physicians who have gained considerable expertise, not only through their training but through their experience, and they are no longer going to be available.

"I still hold optimism for the future, but there are going to be changes in how OBs practice."

Organized Medicine

Experience, knowledge, and involvement at all levels of organized medicine have prepared Dr Nunnelley to lead the Kentucky Medical Association into the New Decade of the Nineties. He speaks humbly of his leadership. "It just evolved over a period of time. Some of it was luck, maybe being at the right place. Shortly after I began practice I was involved in OB/GYN politically, and after only a few years in practice was elected President of what was then the Kentucky OB/GYN Society. Through my association with the Fayette County Medical Society as a member and then as President, I saw how important KMA was, and I wanted to be a part of that movement.

'I hope that during this next year anyone who has a problem will make it known, and we can resolve it to their satisfaction.'

My involvement on a small scale led to being involved on a larger scale, and I think that is why its important that we encourage involvement in organized medicine. Once you are in the door, you realize the impact that KMA can have. It's difficult to be inside shouting out, telling people what you are doing. Once you get them in to show them, they become the people who get involved and want to continue to work."

His hard work and contributions to the Kentucky Medical Association manifest Dr Nunnelley's energy and dedication to the physicians of Kentucky. His slow beginning in organized medicine rapidly escalated and now his curriculum vitae is dotted with official posts and committee memberships. In addition to the presidencies mentioned above, he is a past President of the Lexington-Central Kentucky OB/GYN Society and is President-Elect of the Medical Staff at Central Baptist Hospital. He is also a member of the American Fertility Society, AMA, and a fellow of the American College of Obstetrics and Gynecology. His service to KMA includes 6 years as 10th District Trustee; positions on the Legislative Committee, Nominating Committee, and Physician's Care Operating Committee; and Vice-Chairman, Board of Trustees. Always dedicated to medical education, he is involved at his alma mater as an alumni and has been Chairman of the U of K Fund Raising Committee for several years.

A Major Goal

"My major goal during leadership," declares Dr Nunnelley, "is to take the House of Delegates actions and make those a reality for the year. Of course, there is the ongoing priority from year to year to maintain an effective legislative effort and to formulate our program for the year when the legislature is in session. The Kentucky Medical Association originally was formed to assist physicians not only in their practice endeavors but in areas that allow them to practice medicine as they are used to . . . so in the future, KMA will really continue to function much as it has. The programs, through necessity, will evolve.

A Personal Goal

Aware that everything is far from perfect in the house of medicine and that today's economic, regulatory, and legal pressures make the profession much more difficult, Dr Nunnelley is concerned that overall physician morale is understandably low. "Recent studies indicate that about 40% of physicians said they absolutely would not or probably would not go back to medical school, and most of them don't want their children involved. I think you could say that is low morale.

"I have a personal goal for this year to develop a program that in some way will instill a positive attitude toward medicine so that more physicians are proud that they are physicians and will encourage their own children and others to enter medicine. I would like to see a year of dwelling on good things, good programs. Many of the things we have to deal with are negative — we're always putting out fires — but we must not continue to dwell on these, we must reinforce the positive aspects.

"I would like to be thought of as a strong advocate for the health profession. When addressing students at the University of Kentucky, I emphasize that medicine is one of the few opportunities left that assures one of a good future. Physicians can practice medicine in a large clinic or, if they choose, in a solo practice. The opportunities are tremendous. The financial rewards are certainly adequate, no matter the specialty. I encourage people to enter medicine . . . for many reasons . . . but, I feel the personal reward is by far the number one reason. There is no other profession I can think of where you work with an individual in a one-on-one relationship as much or have the same personal rewards."

Realizing that physicians can no longer acquiesce to the erosions of the doctor-patient relationship and must insist on the right to take care of their patients, Dr Nunnelley faces the issue head-on. "So much of our morale problem stems from outside sources. Physicians can live with being told what we will be paid, even though we don't like it. However, we have a real problem with being told how to practice medicine. Can this patient be admitted or not? This patient is very ill, can I keep her one more day? Naturally this affects morale. We've gotten hung up on government intervention and professional liability. These are real, but there are better things to discuss. For this reason, I hope to develop a presentation to take into the various county societies to promote optimism, with the hope that we can reverse some of the negative trend."

'Organized medicine is going to become much more important in the future. This is one of the most important organizations any physician can join.'

The Legislature and Control of the Profession

The 1990s hold many changes for medicine. Change is the key word now. Many physicians find it difficult to change and resent the intrusions that have been forced into the relationships they have with their patients — and with each other, for that matter. Dr Nunnelley recognizes that combating this will require that KMA direct an increasingly larger portion of its efforts toward the legislature.

"When you realize the federal government, through Medicare, Medicaid, and state government, is responsible for approximately 45% of the health care dollar, and much of this goes through the legislative process and through regulation, you realize that more of our time must be devoted to this area. The largest growing segment of our population is the over 80 group and more people are falling under the Medicaid financial limits. Government control of the health care dollar continues to grow, and it is going to be important for the Kentucky Medical Association to monitor these efforts so they can allow physicians to continue the practice of medicine. Otherwise, we are likely to see total government control."

Cognizant that the formation of new policies and the commitment by physicians to search for workable programs are ethical pursuits and should not be thought of as "political" and outside their realm, Dr Nunnelley encourages *all* physicians to become involved in the legislative process. "Physicians are not as involved as they should be, but they are much more involved than ever before. We are seeing an acceleration in all phases of the political process — federal, state, and judicial areas. There is deeper awareness that the legislative process controls much of our profession, and if we take a passive attitude, we are going to lose control."

In his conversation concerning the legislature, Dr Nunnelley's message is clear — when formulating programs that ensure equity in quality care, fear of economic costs should not prevail over quality care. "Unfortunately, in the political arena, it's not a matter of quality care, it's more the bottom line of care. How much does it cost? How much are we spending? How can we reduce that? Many of the programs are to curtail costs rather than maintain quality of care. We physicians can point out to our representatives in the political process 'Look, we know medicine is too high, and we would like to bring the cost down. But don't sacrifice quality of care for cost. If we can reduce cost and maintain quality, then fine.' We must keep reinforcing this.

"1990 was one of our better legislative years," continued Dr Nunnelley, "and it was a positive year for a change. In other words, we introduced positive legislation. Normally, we're there in a negative capacity as a result of others introducing legislation that is not good for medicine or not to the benefit of physicians. We fared well in the 1990 KGA. The AIDS bill, protection of pension plans, the living will, indigent care, and others were successful because we worked hard this past year. Considerable progress was made, even though all of our bills did not pass. By taking advantage of this opportunity and being present to testify on what is really happening, we received good publicity and the results will be far-reaching. We laid the groundwork for the next session."

Health Access America

"This major program encompasses every phase of society. It tells the American people that organized medicine — AMA, KMA, local societies — is willing to take a stand by presenting this program. In no way are they indicating this is the only way to solve the problem. Hopefully, this program puts us in the forefront in trying to resolve this issue, and it gives consideration to every phase of indigent care regardless of ability to pay. It's an ambitious program, and I don't think everything will be done. It will start a dialogue with other organizations interested in the problem, and hopefully from this beginning a program will be formulated to care for these people."

'Government control of the health care dollar continues to grow, and it is going to be important for the Kentucky Medical Association to monitor these efforts so they can allow physicians to continue the practice of medicine. Otherwise, we are likely to see total government control.'

Ever the patient's advocate, it is apparent that Dr Nunnelley feels that physicians have a primary responsibility to their patients and must be prepared to adhere to high standards of quality care. Each individual patient is important to him, and any form of socialized medicine is unacceptable. "My feeling is the American people want traditional health care — the way it has been. This is the care they have grown to expect. People who have been exposed to the Canadian system and the system in Great Britain think it's terrible to wait 6 months for a hip replacement or have a hernia cared for. In England, dialysis is unavailable after a certain age which, unfortunately, is when most dialysis is needed. Do we want our grandmother to have access to dialysis and live a perfectly normal life? Sure we do. Our

patients are demanding when it comes to health care in the US. This is not to say everyone is willing to pay, but they want the modern technology, the best care available."

Kentucky Physicians Care

"No one was willing to step forward and take responsibility for indigent patients. But Kentucky did. Kentucky started the Physicians Care Program. This is an excellent program. It's been a model that other states have attempted to copy. The magnitude of the program is changing by the addition of contributions from the drug companies, particularly Pfizer Labs. I think that other drug companies will be coming on board and there will be more hospital involvement. This is the type program that can work for short periods of time; it is not a long-term answer. We've met the challenge. We've met current needs. Now we must take the information and experience we've gleaned and develop it into a program that the state or the federal government recognizes and is willing to adopt in caring for the indigent, much as the Health Access America program."

When it comes to the new leader of KMA, care of the indigent or less fortunate is obviously not to be relegated to programs or the efforts of others. Those who know Preston Nunnelley know that here is a man who has never lost his idealism and his commitment to helping the less fortunate, even when it costs him personally in both time and money. His dedication is well documented. Founder and Director of the Fayette County Indigent Prenatal Clinic through the Fayette County Health Department, Secretary-Treasurer of the Lexington Ronald McDonald House, and several awards recognizing his work in prenatal care, are but a few involvements attesting that Dr Nunnelley has contributed many hours to the care of the needy. We can only admire his dedication.

Costs, The Aging, and Technology

"I think we're only seeing the tip of the iceberg in health care costs. Obviously, I see no way they are going to drop suddenly. With an aging population comes specialized health problems. One statistic states that 60% of our health care is spent on people over 60 and that 60% of that is spent in the last year of their lives. That's a tremendous amount of money, but that's the way we want it in America. We want to give everyone the opportunity to have a good quality of life. It's going to cost more — that's the bottom line.

'If we were sitting at this interview in the year 2000, we would look at the 80s and think that many advances were very primitive. I foresee an explosion of new technology for the 90s.'

"New technology, new medications, different equipment, AIDS — which can do nothing but increase health costs, a growing population, are all evidence that we're not dealing with a static component. The change is rapid.

"If we were sitting at this interview in the year 2000, we would look at the 80s and think that many advances were very primitive. I foresee an explosion of new technology for the 90s. Walk through a hospital right now . . . 50% of everything you see was not there 10 years ago.

"We made great strides in the 80s but there will be even more in the 90s. Surgical techniques that are not as invasive, but certainly expensive to develop; new medications for and prevention in cancer therapy; and AIDS research that I strongly feel will lead to a resolution of this problem are but a few of the efforts that will gain momentum in the 90s. The public must be educated on the cost of this escalating technology. The media keep the public aware of what's available, but patients must know if they want the latest in technology, someone has to pay.

"This is one of the problems we have," continues Dr Nunnelley. "There will be two articles on one page of the newspaper. One covers this great new technology that is doing wonderful things for people, it's prolonging and improving the quality of their lives. In the next column is an article critical of health care costs. Side by side. The public nor the media seem to understand that these are not separate issues — they are tied together."

Membership in KMA

Preston Nunnelley's quiet demeanor belies a passionate zeal for the Kentucky Medical Association, and realizing that membership means the life blood of the organization, he emphasizes that all Kentucky physicians need to be involved. "Each individual is very important, but it's difficult for a single person to make their voice heard, either from an economic standpoint or from representation. When we pool our resources and have a large united voice the advantages are so much greater for accomplishing goals. The Kentucky Medical Association represents you, hopefully your individual views, but as a large body with many members, we can have greater impact on the forces opposing medicine.

"Organized medicine is going to become much more important in the future. This is one of the most important organizations any physician can join. We have representatives monitoring every medical situation, monitoring what's going on for us, to keep us

KMA President Nunnelley is pictured with his family — (L to R) sons Bart and Ryan, wife Lucille, Dr Nunnelley, and son Rick.

informed so we can do something about it. Participation is increasing. Physicians are realizing the importance of organized medicine and want to be a part of it."

Another way to support KMA as the powerful influence it is, and has been, and will continue to be is through KEMPAC, the Kentucky Medical Political Action Committee. "KEMPAC is very important. Our dollar goes further in KEMPAC. Many times it gives our organization an opportunity to support and foster your own philosophy by supporting a candidate who will do the same thing. KEMPAC is beneficial to us in our legislative effort, it makes our work in Frankfort much easier."

Family and Interests

Dr Nunnelley is very much a family man. He and his wife, Lucille, have three sons. Against the odds, their teenage marriage has lasted for 30 years. "My wife is the stabilizing force in the family. Obviously, I'm away from home a lot, so Lucille is the homemaker and the mother and the wife and has done an excellent job in supporting us. She's the backbone — the supporting part."

His expression is one of pride as Dr Nunnelley discusses his sons. "Our eldest son Rick is 24 and will earn his law degree this year from the University of Louisville. The middle son, Ryan, who will be graduating this year from Transylvania University, is 21. Bart, the youngest at 16, is a junior at Henry Clay High School. He's playing football, and I really enjoy his practices and make sure I attend his games. Unfortunately, I missed photo day today. Most of the time I make arrangements to attend the events that are important in their lives, but with the KMA Board meeting today, I couldn't cancel out."

Dr Nunnelley is thoroughly committed to the care of his patients and to his profession. He has few distractions or hobbies. His "free time" is spent relaxing at his favorite hobby, golf, or indulging a fascination with computers. "I have an individual computer in my office, and I'm constantly searching for new ways to use it. There are some excellent prenatal care programs. Prescription writing on the computer provides excellent records. Tying in with professional liability, one very important area for the use of computers in medicine is recall. Reminders pop up on the screen to send letters for follow-up pap smears, mammograms, etc. Recall is going to play a larger roll in the use of computers in medicine."

The KMA Presidency

"Two accomplishments during this year will leave me with a feeling of success as President of KMA. If I fulfill my obligation to carry out the business of the House of Delegates in a fashion they are proud of, and if in some way when I leave there is more pride in medicine, people are talking more about the positive aspects of medicine, then I will feel I've accomplished what I possibly could during my tenure.

"I want my colleagues to remember me as a President who was not only concerned about the big issues, but all the issues that face physicians, whether they be a single person practicing in a rural area or a large group practicing in a metropolitan area. So many times individuals, particularly in the more rural areas, feel they don't have a voice, that no one is listening. I hope that during this next year anyone who has a problem will make it known, and we can resolve it to their satisfaction."

Approachable . . . that's KMA's new President, Preston P. Nunnelley, MD.

Sue Tharp
Managing Editor

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AIR FORCE

To the Editor:

We have recently had the opportunity to serve on the Government Relations Advisory Committee as part of the Arthritis Foundation and have met with Medicaid representatives on a regular basis regarding the use of nonsteroidal anti-inflammatory agents. As you are aware, these have recently gone back on automatic authorization. The current system has greatly streamlined the use of these medicines when compared to the previous authorization system. There were several things that brought this about, one of which was the greatly increased use of these drugs and the feeling based on very close monitoring that these were being used somewhat inappropriately and being used where less expensive drugs could be utilized.

During the monitoring, there were several points which were brought to the attention of the Government Relations Advisory Committee. First was the use of multiple nonsteroidals simultaneously. This practice is rarely indicated and it is potentially quite harmful. In many instances, physicians who were notified by the Medicaid office responded well, but there were also instances in which they simply answered that "this is our practice." As one who uses these agents on a regular basis, I am unaware of any rationale nor approval for these drugs being used simultaneously. There is potential toxicity to the stomach and kidneys, especially in the elderly population. To our knowledge there is no significant data to support additional efficacy.

Another question which came up was concomitant use with Coumadin or Warfarin. Ideally, NSAIDs and these agents should not be used simultaneously, but there certainly are instances in which it is necessary for the patient's well being. In these instances, there are no clear-cut guidelines, but it is generally recommended that short-acting drugs be used so that their antiplatelet effects will be more easily reverent. It would also be reasonable to use a drug such as Cytotec concomitantly with the NSAID in the attempt to reduce the incidence of ulcers and gastrointestinal bleeding.

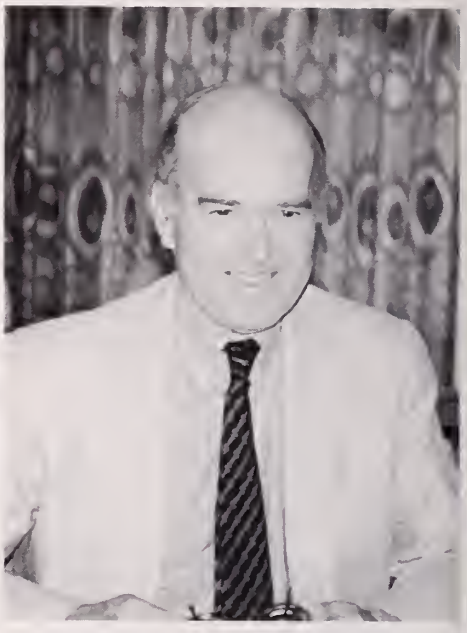
The use of inappropriate doses has also been noted. Many times the drugs were underdosed and were given only for a few days at a time. When using these drugs as anti-inflammatories for arthritis, it is best to administer for at least five half lives and as a clinical rule generally to go at least three to four weeks on a single drug before it is declared not useful. Many times we would see several prescriptions given out at one time for only three to four days each. In inflammatory conditions, this is simply not an adequate time for a drug to be of use.

Also, many times these drugs were used as analgesia. While most of them are, in fact, approved or used as analgesics only, generally there are far less expensive alternatives for patients than the nonsteroidal agents.

Paul M. Goldfarb, Jr, MD
C. Richard Gill, MD
David Neustadt, MD
Government Relations Advisory Committee
The Arthritis Foundation Kentucky Chapter

Board of Trustees August Meeting

President Nelson B. Rue, MD, Bowling Green (L), is seated with President-Elect Preston P. Nunnelley, MD, Lexington.



S. Randolph Scheen, MD, Louisville, KMA Secretary-Treasurer.

Auxiliary President Betty Schrodt, Louisville, presented a report to the Board.

The KMA Board of Trustees held its fourth meeting of the Association year on August 8-9, 1990. Reports were given by the President; Auxiliary President; Secretary-Treasurer; Commissioner for Health Services; Dean, U of L School of Medicine; and representatives of the Kentucky Medical Insurance Company. The Senior Delegate to AMA highlighted actions taken at the AMA Annual Meeting in June, and the President of the Kentucky Board of Medical Licensure summarized activities of the BML during the past year.

A special presentation was made to Hoyt D. Gardner, MD, Louisville, in appreciation for his dedication to organized medicine. He was presented with a portrait of himself which will hang in the KMA Headquarters Office.

Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities (COSLA), reported that each KMA member had received the "1990 KMA Legislative Report," a summary of action by the 1990 Kentucky General Assembly. The Board adopted several recommendations of the COSLA relating to Certificate of Need for referral to the 1990 House of Delegates.

It was noted that legal counsel had been asked to prepare an analysis of a new Blue Cross and Blue Shield HMO/PPO contract; and that the PRO Advisory Committee had investigated several incidents involving Sentinel Medical Review. The Board members received a copy of "A Syllabus of Sports Injury Care for the Kentucky High School Coach"; and approved the use of KMA's name as a cosponsor of a Board of Education program on drug awareness.

The Board appointed Jannice O. Aaron, MD, Louisville, to the *Journal* Editorial Board to fill the vacancy created by the death of David L. Stewart, MD, Louisville; and submitted the name of Donald C. Barton, MD, Corbin, to the Health Care Access Foundation for appointment to an additional 4-year term.

Endorsement was given to a "Patient's Bill of Rights," formulated by the Ad Hoc Committee on Quality of Care, and to the AMA's "Health Ac-

Chairman William B. Monnig, MD, presided at the meeting of the Board.

cess America" program, and both were forwarded to the House of Delegates via committee reports.

The Board authorized a $10 voluntary billing for the Legal Trust Fund for 1991, and approved payment from the Fund for two lawsuits in which KMA has filed amicus curiae briefs. It also approved an increase in subscription rates to the *Journal of the Kentucky Medical Association.*

The ad hoc committee reports of the Board were finalized, and a review was made of each final report submitted by the KMA committees. A list of actions taken by the 1989 House of Delegates was distributed for review of the implementation of each action, and it was noted that the same information would be sent to every Delegate as an addendum to the Board Chairman's Report to the 1990 House. The Board also approved several Resolutions for introduction into the House.

The next meeting of the Board was scheduled for Sunday, September 23, 1990.

Wally O. Montgomery, MD, Paducah, Chairman of Committee on State Legislative Activities.

Donald R. Kmetz, MD, Dean of U of L School of Medicine.

Royce E. Dawson, MD, Owensboro, President of Board of Medical Licensure.

Ron N. Collier, MD, Louisville, Vice Chairman, KMIC Board of Directors.

Hoyt Gardner, MD Honored by KMA Board

Hoyt Gardner, MD, Louisville, and wife, Rose, stand by his portrait that will hang in the KMA Headquarters office.

For his many years of dedicated service to the Kentucky Medical Association, Dr Hoyt Gardner, of Louisville, was honored by the Board of Trustees at the August Board meeting. Board Chairman William B. Monnig, MD, commended Dr Gardner for having given much of his time, talent, and efforts specifically to the activities of KMA and unveiled a portrait which will hang in the Headquarters Office.

A gentleman who in 1978 capped an extraordinary career by assuming the office of President of the American Medical Association, Hoyt Gardner, MD, preceded this accomplishment with a remarkable list of professional highlights. President of the Jefferson County Medical Society and the Kentucky Medical Association; charter member and past Chairman of the KEMPAC Board of Directors; Chairman of the AMPAC Board of Directors; Trustee of the AMA; a member of the prestigious AMA Council on Legislation; KMA Chairman for National Affairs; and a US Delegate to the World Health Organization Assembly in Geneva, Switzerland are included in that list.

Dr Gardner has also been dedicated to his civic responsibilities. He has served as Chairman of the University of Louisville Board of Trustees, Chairman of the Louisville-Jefferson County Board of Health, and President of the Medical Alumni Association at the University of Louisville. Dr Gardner is a military veteran, having served with the Navy in World War II and with the Air Force during the Korean conflict.

It is not surprising that richly deserved recognition came to Dr Gardner in 1979 when he was honored by his Alma Mater, the University of Louisville, with its annual "Outstanding Alumni Award," and again in 1986 when the Kentucky Medical Association presented him its highest award, the KMA Distinguished Service Award.

In his presentation, Dr Monnig stated, "Today, this Board of Trustees pays special homage to you, Hoyt, for your service and devotion to the State Medical Association and to the causes we espouse." Dr Monnig also included Mrs Gardner in his tribute. "We are also pleased that Rose is with us today. She has walked shoulder to shoulder with Hoyt as he has progressed through his career and she too has been an inspiration to all of us who have grown to know and love her." ***kma***

PEOPLE

Fred Caudill, MD, a psychiatric resident at the University of Louisville Department of Psychiatry is the 1990 recipient of the Community Psychiatry Award. This is the first year of the annual award program which is sponsored and underwritten by Seven Counties Services, Inc.

The award is for the resident who has shown high achievement and promise in the field of public sector psychiatry during residency.

Nominations for the annual award were reviewed and approved by a committee which included KMA members **Clifford C. Kuhn, MD,** professor, associate chairman and director of Community Psychiatry, the Department of Psychiatry and Behavioral Sciences at the University of Louisville, and **John P. Bell, MD,** former Director of Emergency Psychiatry Services.

Joseph B. LeRoy, MD, University of Louisville School of Medicine, has been invited by the National Board of Medical Examiners to serve on the Clinical Competence Examination Committee for 1990.

Max A. Crocker, MD, of Lexington is the Kentucky Academy's candidate for the AAFP Board of Directors. Dr Crocker currently is a member of the Commission on Continuing Medical Education.

In the past, he was a member and chair of the Mead Johnson Awards Committee.

He is a past KAFP president and is a delegate to the AAFP Congress.

Dr Crocker is professor in the Department of Family Practice at the University of Kentucky. He is an AAFP Charter Fellow and an ABFP Diplomate.

Nemr Eid, MD, Assistant Professor of Pediatrics, University of Louisville, will make a presentation entitled, "Comparisons of DNA Restriction Endonuclease Analysis (REA) of Pseudomonas Aeruginosa from Cystic Fibrosis Patients" in a Scientific Paper Symposia entitled "Cystic Fibrosis and Bronchopulmonary Dysplasia" during the 56th Annual Scientific Assembly of the American College of Chest Physicians to be held in October in Toronto, Ontario, Canada.

David Adamkin, MD, Associate Professor of Pediatrics, University of Louisville, and President of the Kentucky Perinatal Association, reports the Association held its Second Annual Meeting in June, 1990, at Barren River State Resort Park in Glasgow, KY. The topic of this year's meeting was "Prevention and Interventions in Teenage Pregnancy."

The Kentucky Perinatal Association, a relatively new organization, is an action group of health care providers, consumers and organizations with a common purpose toward recognition of maternal-infant health care issues and dedicated to the provision of comprehensive solutions through educational outreach and advocacy. Members of the Kentucky Perinatal Association are also members of the National Perinatal Association.

Membership in the KPA is open to all individuals and organizations interested in any aspect of perinatal care through the Commonwealth of Kentucky. In addition to the opportunity for access to others sharing your interest in perinatal health issues, the KPA offers reduced registration fees at many statewide conferences and meetings — among them the Newborn Symposium and High-Risk Obstetrics held in Louisville — as well as meetings of the SPA and NPA. Membership dues are $35 annually; members will receive several newsletters as well as the *Journal of Perinatology* at a reduced rate. For additional information or membership forms, contact David Adamkin, MD, Division of Neonatology, Department of Pediatrics, 502/562-8626.

UPDATES

Laser Improves Vision of Nearsighted Patients

The University of Louisville reports that a Louisville ophthalmologist is using laser technology to correct nearsightedness and other severe vision problems.

Richard Eiferman, MD, uses excimer laser light rays to reshape the curvature of the cornea. Unlike radial keratotomy, in which small cuts are made, the excimer rays basically mold the eye into its proper shape without risking permanent damage, according to the University.

Dr Eiferman says the procedure has restored most patients' vision to 20/20.

Doctors Need More Than Medical Skills

Richard Blondell, MD, University of Louisville, says business skills are vital for physicians. He directs a medical business management program for family practice residents. Business school faculty teach courses in economics, financial planning, human resource management, marketing, and promotion.

The residents learn skills to help with everything from handling complicated business matters to keeping appointments.

UK College of Medicine Plans New Curriculum

A call for reform of medical education by leading medical educators,

students, and expert observers has prompted the Robert Wood Johnson Foundation to award the University of Kentucky College of Medicine nearly $150,000. The UK College of Medicine was chosen as one of 12 medical schools to participate in the Foundation's initiative, "Preparing Physicians for the Future: A Program in Medical Education." In addition to Kentucky, grants were awarded to Yale, Johns Hopkins, Case Western Reserve, Brown, and Columbia universities, and the universities of Chicago, Rochester, Nebraska, New Mexico, Oregon and Hawaii. Approximately $1.8 million was awarded nationwide for the first phase of the project.

"We are in excellent company. The schools that were selected for the grant are considered some of the most outstanding schools in the country and we appreciate being included in that group," said **Emery A. Wilson, MD**, dean, UK College of Medicine. "However, this grant does more than just provide us with national recognition. It allows us to concentrate on new methodologies and educational techniques that hopefully will result in a more sophisticated curriculum for medical students."

UK College of Medicine associate dean for academic affairs, **H. David Wilson, MD,** believes that several factors led to the selection of UK. "We have all the tools to do the job," he said. "We have a gifted and sensitive faculty. We have an excellent and highly selected student body. I think the Foundation was impressed with this combination of a dynamic leadership and an altruistic student body. I also think they were impressed that we have taken a lead already by introducing several innovative changes into our curriculum."

In 1989, the College became the first medical school in the country to introduce an accelerated family practice program. The program, designed to recruit more family physicians, allows students to complete their medical education and training in six years, instead of the usual seven. In addition, the College was the first to provide a problem based learning curriculum during the junior surgical clerkship in the clinical years without having a problem based curriculum during the pre-clinical study years. The concept allows students to problem solve through interaction, rather than by lecture.

The Robert Wood Johnson Foundation was established as a national philanthrophy in 1972. Since then, it has awarded more than $1 billion in grants to improve healthcare in the United States.

OPSF Offers Scholarships in Occupational Medicine

The Occupational Physicians Scholarship Fund (OPSF) is offering stipends to physicians who plan to enter the field of occupational medicine.

Scholarship awards with a value of $25,000 to $35,000 annually may be renewed a second year and will be given strictly on merit.

The scholarship fund, under the auspices of the American College of Occupational Medicine, is intended to support health care practitioners during training in an accredited occupational medicine residency program.

Following at least one year of clinical training, occupational medicine programs offer training in epidemiology, biostatistics, environmental health and health care administration along with required practicum experiences including industrial rotations.

Prospective students may attend any approved residency program they choose. The OPSF stipend, based on federal stipend levels appropriate for years of training, will be awarded upon acceptance into an occupational medicine residency program.

The fund was established in an effort to attract physicians to the field of occupational medicine. Corporations and individuals have contributed more than $4.3 million to the fund since its inception in 1987.

Complete information about the scholarships is available by writing to the Occupational Physicians Scholarship Fund, American College of Occupational Medicine, 55 W Seegers Road, Arlington Heights, IL, 60005.

Deadline for completed scholarship applications is January 1, 1991.

Oral Vaccine Approved for Typhoid Fever Provides International Travelers Fast, Safe Protection

A new oral typhoid vaccine was approved for marketing by the Food and Drug Administration and is now available throughout the United States.

The vaccine, Vivotif Berna (Typhoid Vaccine Live Oral Ty 21a), is a live-bacterial vaccine in a coated two-piece capsule. Four capsules are required for protection, one on each alternative day for a total of 6 days. A booster dose is recommended after 5 years if exposure to typhoid is continuous or repeated. The vaccine is considered novel because it is the only live bacterial vaccine approved in the US that is administered orally.

New recommendations for typhoid immunization by the Immunization Practices Advisory committee, Centers for Disease Control, MMWR 1990;39 (No. RR-10) confirm the Vivotif live oral vaccine as safe and effective protection against typhoid.

The vaccine was developed and is manufactured by the Swiss Serum and Vaccine Institute, Berne, Switzerland. It is distributed in the US by Berna Products Corporation (Phone: 1-800-533-5899) of Coral Gables, Florida.

Kentucky Medical Association Physician Placement Service Discontinued

In 1978, the Kentucky Medical Association began the Physician Placement Service in order to assist communities in locating physicians

and to encourage physicians to practice in Kentucky. This service has been provided at no charge to participating physicians or communities.

The 1990 General Assembly passed Senate Bill 239 to establish physician recruitment and placement services through both the University of Kentucky and the University of Louisville. Beginning in July 1990, the Legislation provided appropriations for administrative costs associated with the placement services and established a schedule of fees the universities will charge when the service is used.

Because KMA's service duplicates that enacted by the Legislature, the KMA Physician Placement Service was discontinued effective July 1. The final issue of the Practice Opportunities Booklet provided by the Placement Service was published in July.

Inquiries regarding the university placement services may be addressed to:

Janice Hurst
University of Louisville
AHEC/PEPP Programs
School of Medicine
218 S Scott St
Madisonville, KY 42431
502/821-3647

Physician Placement Specialist
University of Kentucky
Health Sciences Learning Center
UKMC — Room 202
Lexington, KY 40536-0232
606/233-8018

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Adair

Donald E. Shackleford, MD — OBG
105 Westlake Dr, Columbia 42728
1986, U of Louisville

Christian

William E. Sweet, MD — FP
1411 S Main St, Hopkinsville 42240
1987, S Illinois U of Medicine

Kelly S. Tate, MD — FP
1610 S Main St, Hopkinsville 42240
1987, U of Kentucky

George R. Valentini, MD — PS
Trover Clinic, Hopkinsville 42240
1969, U of Paris

Franklin

Douglas H. Rank, MD — P
305 Ann St #404, Frankfort 40601
1984, Baylor

Hopkins

Alejandro Soriano, MD — PD
Trover Clinic, Madisonville 42431
1983, U of St Thomas

Harlan

Lizbeth S. Sussman, MD — N
Daniel Boone Clinic, Harlan 40831
1981, U of the Philippines

Jefferson

Andrew D. Bailey, MD — GE
4001 Kresge Way #134, Louisville 40207
1978, Vanderbilt

Michael J. Imburgia, MD — C
616 Medical Towers, N, Louisville 40202
1983, S Illinois U of Medicine

Maria E. Manion, MD — P
4010 Dupont Cir #308, Louisville 40207
1961, U of Buenos Aires

Christopher Payton, MD — AN
3117 Runnymede Ct, Louisville 40222
1982, U of Kentucky

McLean

Robert C. Hoskins, MD — FP
200 KY 82 N, Calhoun 42327
1987, U of Louisville

Northern Kentucky

Philip S. Becker, MD — N
225 Thomas More Pkwy, Crestview Hills 41017
1982, Northwestern U

Allan E. Hallquist, MD — PTH
7380 Turfway Rd, Florence 41042
1981, State U of New York

Taylor

David E. Bentley, MD — S
105-B Greenbrier Dr, Campbellsville 42718
1985, U of South Alabama

Warren

Richard B. Perkins, MD — IM
1 South Creek Dr #117, Monticello 42633
1987, U of Kentucky

New In-Training

UL —
John T. Kenny, MD — **IM**
Kurt F. Kessler, MD — **S**
Frederick J. Stocker, Jr, MD — **P**

DEATHS

Jennings B. Marshall, MD
Louisville
1908-1990

Jennings B. Marshall, MD, a retired OB-GYN, died August 4, 1990. Dr Marshall was a 1936 graduate of the University of Louisville School of Medicine and a life member of KMA.

Felicisim B. Rodriquez, MD
Cincinnati, OH
1927-1990

Felicisim B. Rodriquez, MD, a family practitioner, has been declared deceased. His family reported to his medical society that he and his bride were honeymooning in the Philippines and are assumed to be victims of the recent earthquake. Dr Rodriquez graduated from Manila Central University in 1958 and was an active member of KMA.

Thomas P. Leonard, MD
Frankfort
1912-1990

Thomas P. Leonard, MD, a retired radiologist, died August 9, 1990. A 1936 graduate of the University of Louisville School of Medicine, Dr Leonard was a life member of KMA.

James C. Salato, MD
Columbia
1917-1990

James C. Salato, MD, a retired general practitioner, died August 31, 1990. Dr Salato was a 1946 graduate of the University of Louisville School of Medicine and a life member of KMA.

Impaired Physicians Committee

is for the alcoholic/ chemically dependent physician.

For more information call

502-459-9790

Choosing a Health Plan

One of the problems with health insurance that physicians continually hear about from their patients is that patients aren't sure what types of coverages they should buy and many times find out after they have purchased a plan that it contains a number of exclusions or benefit limitations.

The Kentucky Medical Association has developed the following guide which we hope will aid individuals in their decision making process regarding health insurance.

Please feel free to remove this page and reproduce it as you feel appropriate. We hope you will find this information useful.

What You Should Ask About Your Health Insurance

- May I choose my physician?
- Is my current physician a member of the plan?
- Will my prescription be paid?
- Are x-rays covered by the plan?
- Are office visits covered? Shots (injections)?
- Can I freely choose to see a specialist or must I be referred by my primary physician?
- Does my primary physician control access to specialty consultation?
- May I choose my hospital?
- Will lab tests be paid?
- Will specialists' services be covered?
- Must I have certain surgical procedures done as an outpatient?
- Will I be screened by medical personnel other than a physician before I see my doctor?
- Do I have easy access to a physician on week nights and weekends?
- Will my health care plan cover me for cost of medical treatment at out-of-town facilities when I travel?
- Will dependents be covered if they reside out-of-state?
- Can I get medical advice from a physician over the telephone during nonoffice hours?
- Am I limited to a certain number of routine care appointments?
- Must I schedule my appointments for routine care far in advance?
- Are any illnesses excluded from the coverage?
- May I request a "second opinion" from an outside physician? If so, will I have to pay for it?
- Will I have to pay a deductible or partial payment?
- When and how often are premium rates subject to change?
- Can I be let go from the plan without advance warning or if I use it too much?
- Do I have to fill out claim forms or will my doctor/hospital do that?
- May I use local physicians and hospitals or must I use those approved by the plan, even if I have to go to another community?
- Is my physician required to obtain permission from the plan before services are rendered?
- Will I be covered for urgent care if it is not rendered in a hospital associated with my health care plan?
- What happens if my physician ceases to be a participant in the plan while I am under his/her care?

Basic Health Care Plans

Fee-for-service is the traditional manner of receiving and paying for medical care. You choose your physician, hospital, and any other medical care you need. You are charged for the care you receive. Often, your care is paid for through a health insurance company whose premiums may be paid by employers. You may pay a deductible (an amount you must pay before your insurance company begins paying for your health care), or a co-payment (you pay a portion of the bill and the insurance company pays the balance).

Health Maintenance Organization (HMO)

An HMO is an organization that provides health care to a group of persons for a pre-determined price. An HMO offers broad coverage at a fixed price. The prepaid fee stays the same for a given period of time, usually one year regardless of the amount of health care used. That fee may be paid by you or, in full or in part by an employer, government or some other sponsor. In some HMOs, services are offered only at specific locations by groups of physicians and other health care personnel. You are required to use the HMO facility and staff to receive medical care.

Independent Practice Association (IPA)

An IPA is a type of HMO. Physicians practice in their office and care for both IPA subscribers and other patients. IPAs are formed by physicians who enter into agreements, usually with an employer group or insurance company, to provide medical services to that group's employees. Since the IPA is an HMO, the patient still must choose a particular group of physicians and a specific medical facility from which to receive medical services.

Preferred Provider Organization (PPO)

A PPO is a group of health care providers who agree to provide services to a specific group of patients (usually employment based groups) at an agreed upon rate.

A Word of Caution

Keep in mind that there are many different types of HMOs, PPOs, IPAs, and other insurance plans being offered today. Each of them has specific restrictions as to the type of care you receive, where you receive it and from whom. Before joining any plan, or before changing your current medical plan, learn as much as possible about the options being offered to you. Ask for written information which outlines the pluses and minuses of each option and read it carefully. Before you make a final decision, discuss the options with your personal physician to make certain that you will be able to receive the care you need under the option you choose.

Finally...

You should realize that many employers choose a plan for their employees. You may not have a choice. However, the information and questions contained in this article will, at the very least, make you more aware of your current health care plan.

Your physician is the best person to help you understand what's happening in medicine today. If you have questions about any subject mentioned here, we encourage you to ask your physician.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

WESTERN KENTUCKY — Seeking physicians for evening and weekend coverage in a low volume emergency department. Attractive schedule and compensation. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc, 2240 South Airport Road, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

INTERNAL MEDICINE — FAMILY PRACTICE — Excellent private practice opportunity in western Kentucky to join another physician in a busy practice. Competitive compensation package with shared call coverage. Send CV to: Don Hoit, 11222 Tesson Ferry Rd, Suite 203, St. Louis, MO 63123, or call-1-800-336-3963.

FOR SALE — Modern and in superb condition! Seven *complete* rooms of primary care medical office equipment (including minor surgery). All ready to move into your office space! Selling in distress! Call 502/765-2517 (E-town).

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The AMA
Hospital Medical Staff Section
Sixteenth Assembly Meeting
November 29 - December 3, 1990
The Peabody Orlando
Orlando, Florida

Highlights of the Interim Meeting will include:

- an educational program on Economic Credentialing;
- presentation by the AMA-HMSS Governing Council of reports on medical staff issues including Health Care Cost, Waiver of Confidentiality Upon Application for Reappointment and State Hospital Medical Staff Section (HMSS) Oversight Peer Review Committee;
- recommendation of policy to the House of Delegates on Denial of Payment for Pre-Existing Conditions, Third Party Payors and Patient Care Standards;
- AMA-HMSS Governing Council election for the position of Delegate.

For Information Contact:

Department of Hospital Medical Staff Services
American Medical Association
515 North State Street
Chicago, Illinois 60610
Phone (312) 464-4754 or 464-4761

HMSS

NOVEMBER

1-3 — Clinical Allergy for the Practicing Physician, The Ritz-Carlton Hotel, St. Louis, MO. Sponsored by Washington University School of Medicine. Program Chairman: Phillip E. Korenblat, MD. Contact: Cathy Caruso, Office of Continuing Medical Education, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110; 800/325-9862, 314/362-6893.

4-9 — 21st Family Medicine Review, Hyatt Regency, Lexington, Ky. Contact: Joy Greene, CME, University of Kentucky; 606/233-5161.

8 — Learn & Live Project for Breast Cancer, Clarion Hotel, Cincinnati, OH. Contact: Ken Lawson, Eastman-Kodak; 513/745-6750.

9-10 — 24th Annual Newborn Symposium and 4th Fall Symposium of the Kentucky Pediatric Society, The Seelbach, 500 Fourth Ave, Louisville, KY. Contact: Lynette McInnis, 502/588-5329.

17 — Fluid Resuscitation in the Critically Ill, The Seelbach, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

26 — Dean's Hour — Silas Starr Lecture, University of Louisville, Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

1991

FEBRUARY

Feb-April — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology, Home Study Course A, The Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, 301/955-8594.

MARCH

8-9 – 4th Annual Contact Lens Course, Washington University Medical Center, St. Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110, 800/325-9862 or 314/362-6893.

13-15 — Seventeenth International Symposium on Psychopharmacology, Holiday Inn-Hurstbourne, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

25 — Dean's Hour — W. O. Johnson lecture, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

APRIL

4-5 — Advanced Gynecologic Endoscopy, University of Louisville Health Sciences Center Instructional Bldg, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

11-13 — Treatment of Surgical Spine Disease, The Ritz-Carlton Hotel, St. Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110, 800/325-9862 or 314/362-6893.

14-25 — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology, In-Residence Course B, The Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, 301/955-8594.

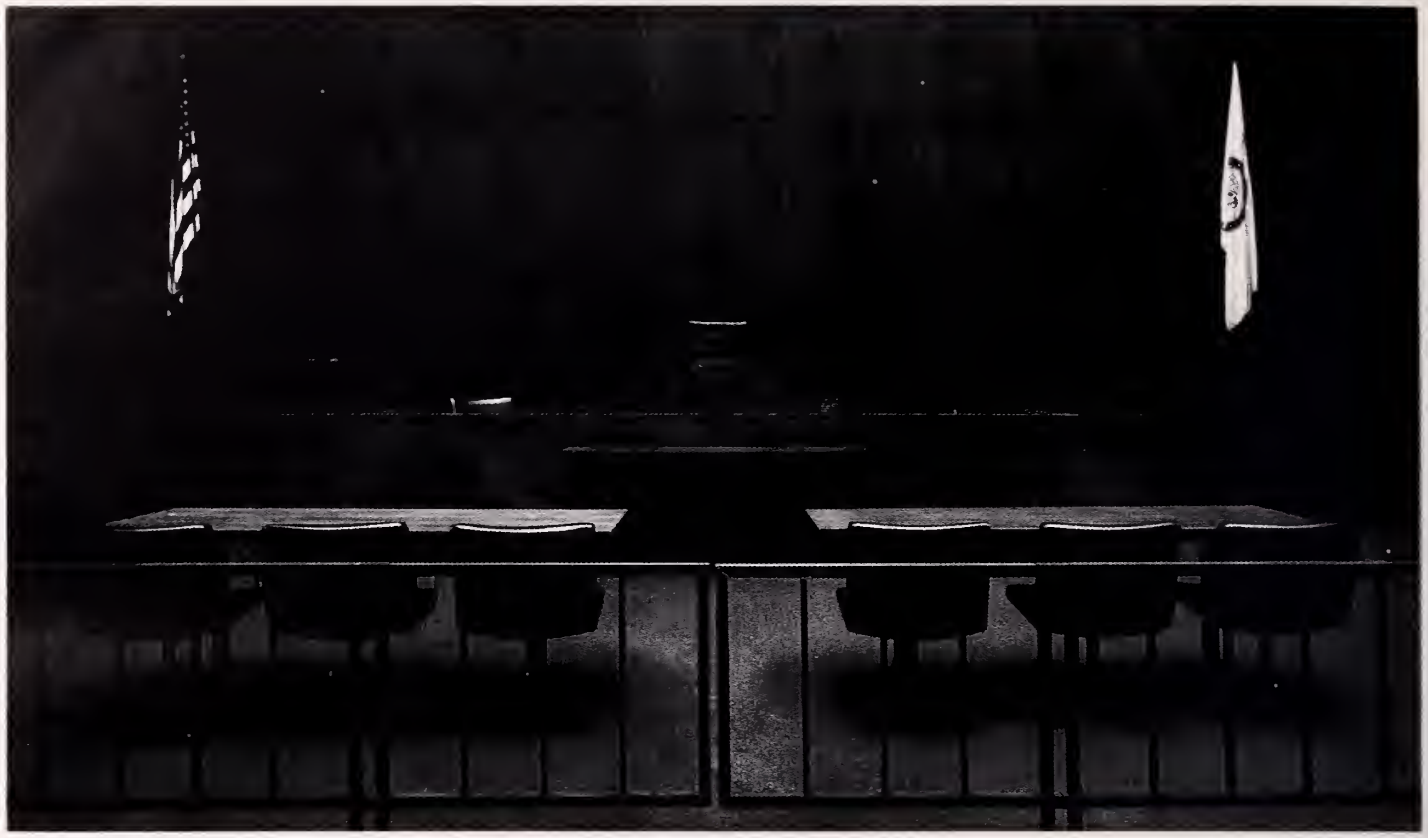
25-27 — High Risk Pregnancy Postgraduate Course, Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

MAY

18 — Nephrology Seminar, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

JUNE

17-21 — Thirteenth Family Medicine Review, Hyatt Regency Hotal, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.



OPERATING ROOM.

No, you won't find gowned-and-scrubbed physicians at work in the courtroom. And yet this arena increasingly demands our attention. Because this is where major issues concerning medicine and our nation's health policies are resolved. This is where physicians' voices must be heard if we are to influence decisions that directly affect our professional lives and the well-being of our patients.

Thanks to the AMA, our voices *are* heard, our interests *are* represented, and we *do* influence national health policies. Since 1984, the AMA's Health Policy Litigation program has enlisted some of the best—and most respected—lawyers from across the country to provide constant and expert advocacy in the courts, particularly the U.S. Supreme Court.

Thanks to an AMA brief, persons with infectious diseases, including AIDS, are protected under the federal law prohibiting discrimination against the handicapped. Thanks to an AMA brief, the Supreme Court held that Health and Human Services regulations affecting physician services under Medicare can be challenged in federal court. And thanks to an AMA brief, the constitutionality of some medical liability tort reform legislation—one possible solution to the professional liability problem—has been upheld at the state level.

Our presence in the courts is one of the most important ways the AMA works on behalf of all physicians. We draw attention to important issues, we register our concerns with *amicus curiae* briefs, we help state and specialty societies present their cases. It's all possible through the support of individual physicians.

Our members make a difference.
If you're already a member, we need your continued support. If you're not, JOIN TODAY.
Call 1-800-AMA-1452

AMA
AMERICAN MEDICAL ASSOCIATION

In most cases, medical association dues may be deductible as professional or business expenses.
Dues and other contributions to the AMA are not deductible as charitable contributions for Federal income tax purposes.

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Contraindications: VASOTEC® (Enalapril Maleate, MSO) is contraindicated in patients who are hypersensitive fo this product and in patients with a history of angioedema related fo previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypofension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azofemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salf depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients al risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of freatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an infravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azofemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE ANO ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents fhat produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, if can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydrafion may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary fo continue the diuretic, provide close medical supervision after the initial dose for at least two hours and unfil blood pressure has stabilized for at least an additional hour. (See WARNINGS and OOSAGE ANO ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by fhiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended thal serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy–Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fefofoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibifors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the pofential benefil justifies fhe potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited fo the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibifion, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given fo a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well folerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances; atrial fibrillation; palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatifis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and OOSAGE ANO ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, finnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentafion rate, arthralgias/arthrifis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermafologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for disconfinuation of therapy in 0.1% of hypertensive patients. fn heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of pafients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponafremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nifrogen and serum creafinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essenfial hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients wifh renal artery stenosis. (See PRECAUTIONS.) In patients wifh heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitanf diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrif (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical frials, less than 0.1% of patients discontinued therapy due fo anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PO deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC fo reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be disconfinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salf substitutes, or potassium-sparing diurefics may lead fo increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for pafients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be fitrafed upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the freatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were freated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See OOSAGE AND ADMINISTRATION, *Heart Failure,* WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., fhen 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deferioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J9VS61R2(820)

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A diminished antihypertensive effect toward the end of the dosing interval can occur in some patients.

For a Brief Summary of Prescribing Information, please see the last page of this advertisement.

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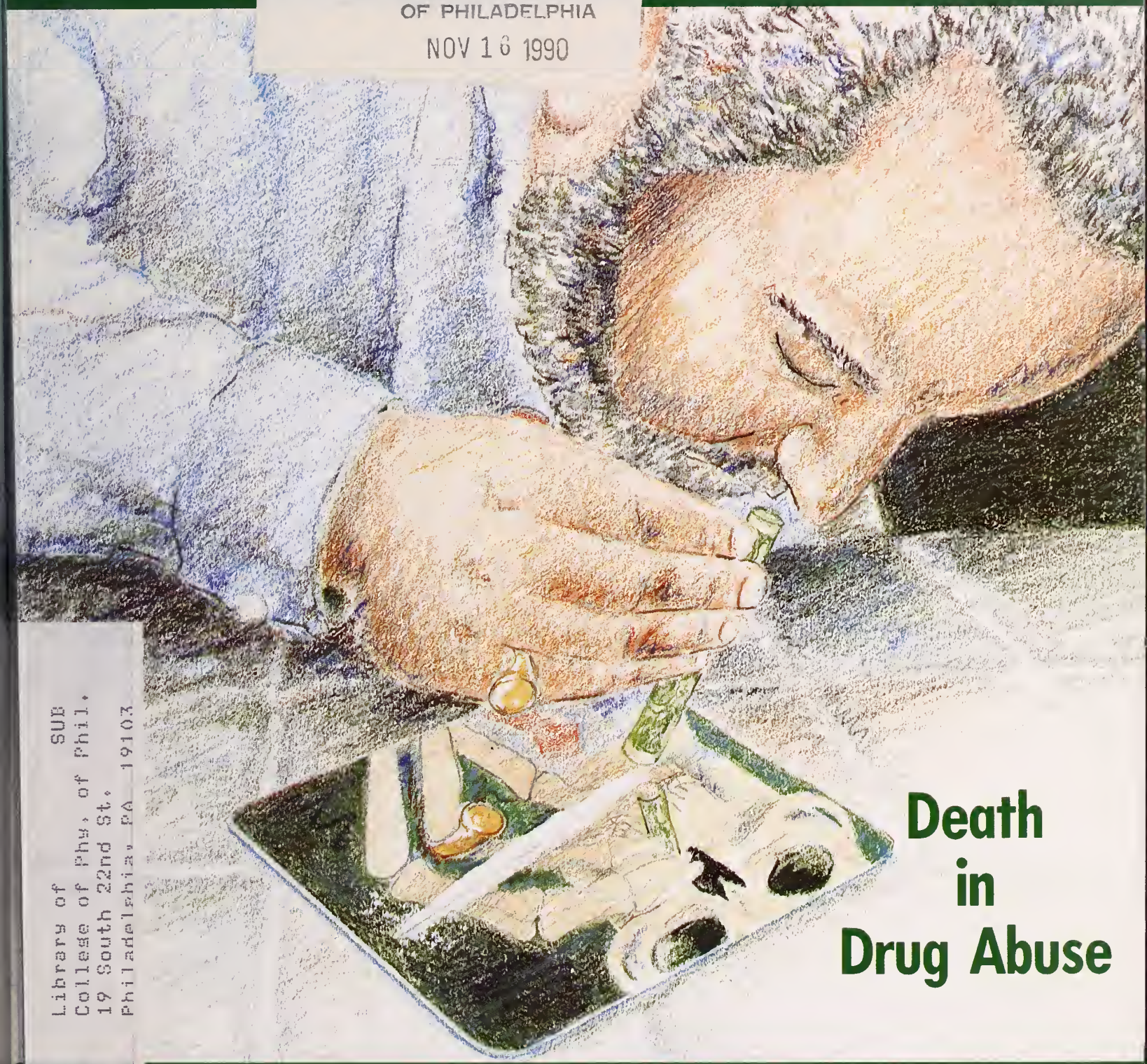

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Call for Kusserow Resignation

'Mr Kusserow is a symbol of the adversarial inconsiderate attitude taken toward physicians today. That attitude creates frustration, stifles initiative, and makes young, bright minds reluctant to enter the medical profession.'

AMA President C. John Tupper, MD, addressed the KMA House of Delegates during the Annual Meeting and discussed AMA's efforts to have President Bush fire Health and Human Services Inspector General Richard Kusserow.

The AMA believes Kusserow acted unfairly and irresponsibly in Medicare and Medicaid fraud investigations of physicians. AMA called for Kusserow's dismissal following a long history of complaints that the Inspector General's office has been unfair to physicians in fraud investigations and violated their constitutional rights.

Mr Kusserow was the focus of the September 20 segment of ABC TV's "Prime Time Live." In that segment, ABC reported that Health and Human Services used a "bounty system" and quotas to reward fraud investigators for bringing sanctions against physicians. Kusserow denied that such rewards had been used, but later admitted that merit pay had been "indirectly tied" to the number of cases brought forth by investigators.

The segment highlighted the career of a rural New York family physician who had been terminated from the Medicare program. The physician became severely depressed, and subsequently committed suicide. The Inspector General, in the 20-20 interview, accused the physician of substance abuse, saying that was the reason for his termination. Kusserow later retracted the statement, admitting it was unfounded. Colleagues, family, and friends of the deceased physician noted that he had been harassed for minor record-keeping flaws.

Mr Kusserow is a symbol of the adversarial inconsiderate attitude taken toward physicians today. That attitude creates frustration, stifles initiative, and makes young, bright minds reluctant to enter the medical profession.

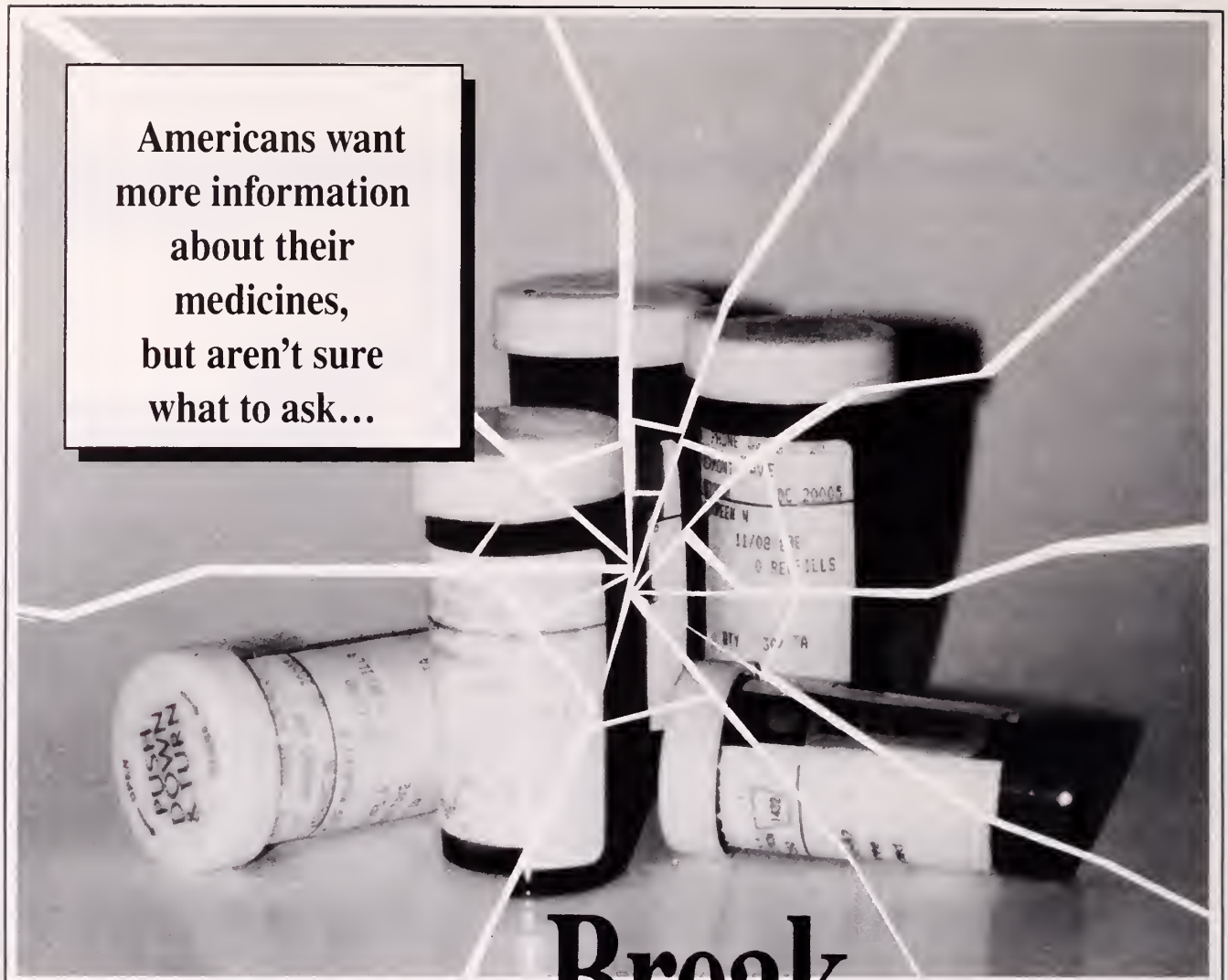
Why does a government of laws rather than of men, which claims to represent the best interest of the elderly and unfortunate, allow a bureaucrat like Kusserow to harrass physicians trying to do their best for patients, the very people government claims to represent? How many more physicians will become reluctant to treat Medicare or Medicaid patients to avoid harassment and public abuse and retaliation? How many more physicians will see their professional careers and lives destroyed by arrogant, overbearing *loose cannons* like Kusserow?

Physicians should be unified in this effort and flood the President's office and the National Republican party with letters and phone calls calling for Kusserow's dismissal.

The AMA is right to call for Mr Kusserow's resignation.

Preston P. Nunnelley, MD
KMA President

'How many more physicians will become reluctant to treat Medicare or Medicaid patients to avoid harassment and public abuse and retaliation? How many more physicians will see their professional careers and lives destroyed by arrogant, overbearing loose cannons like Kusserow?'



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TALK ABOUT PRESCRIPTIONS

Report of Alternate Delegate

A report by Alternate Delegate Larry C. Franks, MD

Since many of us have received "quality inquiries" from Sentinel, it is essential that we understand how to respond. First, do not ignore a quality letter. Second, share your "quality inquiry" with the quality assurance officer or committee of your hospital. It will be kept confidential and will improve your response and eventual outcome. Finally, obtain a copy of the publication,* How To Respond To A Quality Inquiry *and use it.

My first experience at the AMA House of Delegates was overwhelming, exciting, depressing, and reassuring. Initially the immense volume of detailed information to be processed left me feeling very much like the third day of gross anatomy as a freshman in med school. Conversely, experiencing the democratic process at this level is extremely rewarding and reassuring.

My conviction that the AMA is a necessary and viable organization has been strengthened. If the AMA were eliminated tomorrow, another less experienced and less organized group would be formed immediately to fill the void. I am convinced that most of the criticism of the KMA and the AMA is the result of apathy and lack of understanding of the organizations' functions.

Sixty-nine different reports and resolutions were addressed in my assigned reference committee. Dr Swikert has adequately covered the significant anti-hassle legislation (H.R. 4475 and S. 2591) in his September article. Peer review problems, the Georgia Medicare Pilot Project, and the National Practitioners Data Bank were areas of particular interest.

Several peer review issues were addressed. The cost effectiveness of preadmission review is being questioned and will be challenged. The question of due process and legal counsel at every stage of the peer review process is being actively pursued. Perhaps the most helpful discussion relates to "quality inquiries." Since many of us have received "quality inquiries" from Sentinel, it is essential that we understand how to respond. First, do not ignore a quality letter. Second, share your "quality inquiry" with the quality assurance officer or committee of your hospital. It will be kept confidential and will improve your response and eventual outcome. Finally, obtain a copy of the publication, *How To Respond To A Quality Inquiry* and **use it.**

The Georgia Medical Society has encountered monumental problems with the Medicare Pilot Project carried out by the PRO, Healthcare Compare. Retrospective review with *automatic downcoding* and multiple claim denials have resulted in impossible administrative hassles and big dollar refunds for some physicians. Achieving retrospective adjustment of incorrectly denied claims has required physicians to submit on a case-by-case basis, which is frustrating and expensive. The AMA board of trustees is preparing congressional testimony on this project, but little progress had been made at the time of the June meeting. This situation is very disconcerting.

The National Practitioner Data Bank is now a reality, and many concerns exist. The AMA has made extensive efforts to educate physicians in *JAMA*, in leadership conferences, with a videotape made available on

Dr Nelson Rue stated my feelings best . . . "Once again I urge each of you to become involved in organized medicine. You can see that it requires time and effort. It is no longer enough to say that we liked things better the way they were 20 years ago, stick our heads in the sand, and leave the fate of the profession we love in the hands of a few. It is your future! It is my belief that good, strong, aggressive, enthusiastic, positive leadership is our best hope for American medicine."

May 3, 1990, through the AHA, and with a brochure entitled *Information For Physicians On The National Practitioner Data Bank.* This brochure provides us with an overview of the data bank and the implications of this activity. Many concerns continue to be addressed including a reporting threshold that would exempt from malpractice reporting requirements payments of less than $30,000. Other concerns include access of information to attorneys and other parties, proper physician notification of adverse data bank entries, and an appropriate timely dispute process for physicians. Current data bank regulations cannot be changed until the data bank has been in operation for one full year according to the statute. Each of us must make every effort to keep informed about the operation of this latest intervention into the private practice of medicine as we know it.

As evidenced by these brief remarks, I believe my reactions are well-founded. However, our Immediate Past President Dr Nelson Rue stated my feelings best in his September 1990 comments in the *KMA Journal:*

> "Once again I urge each of you to become involved in organized medicine. You can see that it requires time and effort. It is no longer enough to say that we liked things better the way they were 20 years ago, stick our heads in the sand, and leave the fate of the profession we love in the hands of a few. It is your future! It is my belief that good, strong, aggressive, enthusiastic, positive leadership is our best hope for American medicine."

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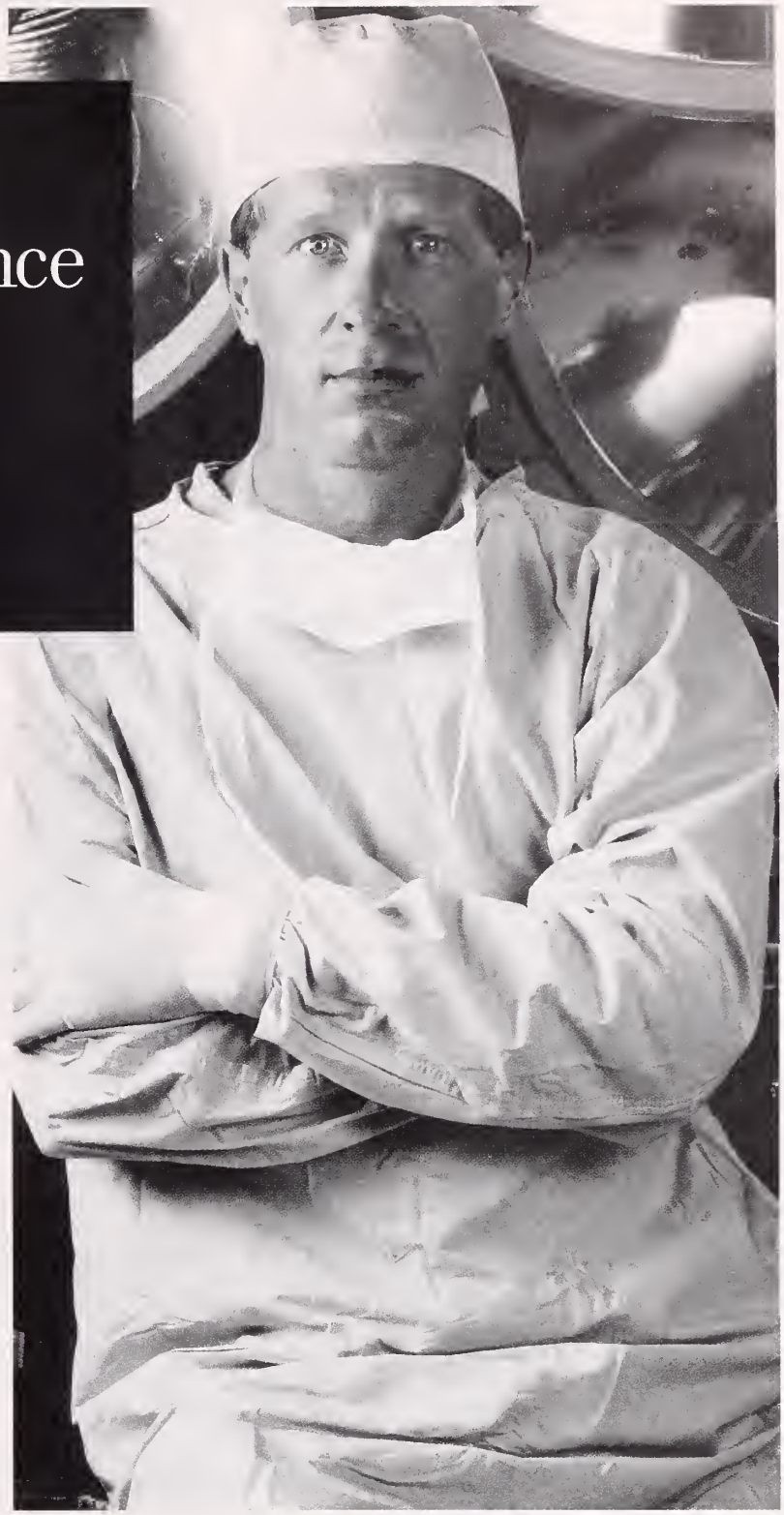

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Death Associated with Abuse of A "Designer Drug"

George R. Nichols, II, MD; Gregory J. Davis, MD; Cynthia A. Corrigan, MD; Jill S. Ransdell, BS

A case of death is reported in a 26-year-old male previously thought to be healthy. At autopsy, the anterior descending branch of the left coronary artery was markedly atherosclerotic with a superimposed thrombus. Toxicologic analysis revealed 3,4 methylene dioxyamphetamine (MDA) in the blood at a concentration of 0.08 mg per deciliter. The authors draw attention to the reappearance of designer drugs in Kentucky and to the need for awareness of these deadly substances.

From the Office of the Chief Medical Examiner, 530 S Jackson St, Louisville, KY 40202 (Drs Nichols and Davis); Department of Pathology, University of Louisville School of Medicine, Louisville, KY 40292 (Dr Corrigan); and University of Kentucky College of Medicine, Lexington, KY 40536 (Senior Medical Student Ransdell).

Case Report

A 26-year-old white male with no known medical problems was observed drinking alcoholic beverages at a party. At 12:30 AM he left the party to go to his truck, where he was discovered dead at 1:30 PM by fellow residents of his apartment complex. Investigation by the coroner's office elicited no significant past medical history. A complete autopsy was performed at the Office of the Chief Medical Examiner. Grossly, the heart was of normal weight; however, the anterior descending branch of the left coronary artery exhibited grade IV atherosclerosis (greater than 75% occlusion of its cross-sectional diameter) with a superimposed thrombus. The only other gross abnormality was found in the thyroid gland, which was of normal size and weight but contained multiple, diffuse areas of pinpoint, white discoloration. Microscopic examination of the gland revealed Hashimoto's thyroiditis. No other gross or microscopic abnormalities were found.

Blood and urine samples were sent to the Toxicology Laboratory of the Cabinet for Human Resources in Frankfort. The qualitative urine drug screen was positive for 3,4 methylene dioxyamphetamine (MDA) by thin layer chromatography, fluorescence polarization, gas-liquid chromatography, and mass spectometry. MDA was quantified in the blood at 0.08 mg per deciliter by gas-liquid chromatography. Additionally, a blood ethanol concentration of 0.03 mg per deciliter was identified utilizing gas-liquid chromatography and fluorescence polarization.

Discussion

"Designer drugs" are drugs of abuse synthesized from commonly available chemicals or by modifying chemical groups on readily available drugs, thereby rendering a new or chemically altered drug not initially regulated by the Drug Enforcement Administration.[1] These drugs, put on the illicit drug market after manufacture in illegal laboratories, have undergone no quality control measures. Their purity is unknown. These drugs may even be a chemically different drug than advertised.[2] This lack of quality control was illustrated tragically in 1982 when the sudden appearance of Parkinsonism symptoms in drug abusers was traced to a single laboratory in California.[3] While attempting to manufacture the meperidine derivative 4-propyloxy-4-phenyl-N-methylpiperidine (MPPP), the laboratory operator inadvertently contaminated his drug with 1-methyl-4-phenyl-1,2,3,6-tetrahydropyridine (MPTP). This latter compound, when oxidized in the brain by monoamine oxidase B, is converted to methylphenylpyridine (MPP+) which selectively attacks the substantia nigra, thus causing a rapid, permanent onset of Parkinsonism.[3,4]

3,4 methylene dioxyamphetamine (MDA) was first synthesized in 1910 by Mannich.[5] Chemically related to both amphetamine and mescaline, the phenylisopropylamine portion of the molecule gives it sympathomimetic activity similar to amphetamine, while its 3,4-methylenoxy group gives it mescaline-like pharmacologic properties.[6] Although it was patented in 1940 as an antitussive,

in 1960 as an ataractic, and in 1961 as an anorexigenic substance,[6] MDA did not gain popularity until 1967, when it began to be abused widely as "the love drug," renowned for its mild intoxicating and euphoric effects.[4] In doses of approximately 120 mg, it gave a sense of well-being with an increase in the perceived acuity of all sensations, but did not cause hallucinations.[7] With higher doses, hallucinations, anxiety, agitation, nausea, bruxism, anorexia, mydriasis, rigidity, pyrexia, and ventricular arrhythmias began to occur.[4] Alarmed at its widespread abuse, the US Government classified it as a Schedule I drug under the Controlled Substance Act of 1970.[7]

Premortem signs and symptoms of MDA toxicity resemble those of amphetamine poisoning. Lukaszewski[8] reported a case of death in a previously healthy 35-year-old male who presented clinically with hyperthermia and erratic behavior. Premortem blood concentration of MDA was 0.23 mg per deciliter. Poklis et al[6] described a case of a 24-year-old white male who demonstrated diaphoresis and bizarre behavior before death with a blood concentration of 1.0 mg per deciliter. Of note, the deceased, himself a drug dealer, thought he was ingesting a mixture of *m*orphine, L*SD,* and *a*mphetamine (*sic* "MDA"). Thus, even the purveyors themselves may be unaware of just what product they are selling. Simpson and Rumack[9] described a death from MDA in another illicit substance trafficer who was initially stabilized but then died with hyperthermia and disseminated intravascular coagulation.

MDA acts as an indirect sympathomimetic agent, causing release of endogenous norepinephrine.[9, 10] Paton et al[10] found that MDA increased the systolic and diastolic blood pressures in dogs and that death in mice from MDA was due to peripheral sympathomimetic action.

Death from amphetamine abuse has long been known to be due to cerebrovascular hemorrhage, hyperthermia, and ventricular arrhythmia.[11] MDA also causes death in a similar fashion.[12] Individuals with underlying illnesses subject to exacerbation with adrenergic stimulation, such as our case with occult coronary artery disease, or those with cerebral vascular aneurysms, cardiomyopathy, or mitral valve prolapse may die from even small doses of the drug.[4]

Chemical relatives of MDA have also been implicated in deaths. Dowling et al[13] reported five cases of death in individuals from 18 to 32 years old within a 9 month period in the area surrounding Dallas, Texas. All of the deceased were taking either 3,4-methylene dioxymethamphetamine (MDMA, "Ectasy") or 3,4-methylene dioxyethamphetamine (MDEA, "Eve"), analogs of MDA formerly thought to be safe and effective adjuncts to psychotherapy. Three of the five cases had underlying natural disease which precipitated a fatal arrhythmia. Suarez[14] described a case of sudden death in a 34-year-old white male with Wolf-Parkinson-White Syndrome who had a blood MDMA concentration of 0.2 mg per deciliter.

Conclusion

Drug abuse continues to take its toll on our Commonwealth and the nation. The advent of new more potent designer drugs poses difficulty for legal and medical personnel alike. A single gram of designer drugs such as 3-methylfentanyl, 6000 times as potent as fentanyl, can be divided and distributed as thousands, perhaps a million, doses.[1] Medically, a negative complete toxicologic workup (urine, gastric aspirate and serum) in the face of a clinical picture of drug abuse may indicate that a new analog, undetectable by the usual means, has entered the market.[3] In this context, all clinical physicians must maintain a high index of suspicion for designer drugs. For the pathologist, a toxicologic workup is indicated when any young person dies of an apparently "natural" disease.[15]

ACKNOWLEDGMENT

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CAGE

Questionnaire

For the Diagnosis of Alcoholism

C = Have you ever felt you should **cut down** on your drinking?

A = Have people **annoyed** you by criticizing your drinking?

G = Have you ever felt bad or **guilty** about your drinking?

E = Have you ever had a drink first thing in the morning **(eyeopener)**?

Positive CAGE Answers:

1 = Suggestive 2 = Probable 3 and/or 4 = Diagnostic

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The Presentation and Treatment of Acute Cocaine Intoxication:
Experience of a Teaching Hospital

Mark V. Burns, MD; Fred T. Dow III, MD; Alan Cox, MD; Thomas M. Roy, MD

From the Division of Respiratory and Environmental Medicine, University of Louisville School of Medicine, 550 S Jackson St ACB-3, Louisville, KY 40292.

Cocaine's for horses, not for men.
Doctors say it'll kill you,
But don't say when.
Cocaine,
Rolls all around my brain.
— LYRICS, COCAINE BLUES, CIRCA 1920

With the use of cocaine now at epidemic proportions, primary care physicians have a reasonable probability of having to provide medical care for a cocaine abuser. Because the cocaine reaction may progress rapidly to a fatal outcome, it is essential to know how to recognize and manage the symptoms of cocaine overdose.

Introduction

Each day approximately 5000 people use cocaine for the first time,[1] making illicit cocaine usage one of the most deadly and dangerous practices in the United States. Reasonable estimates suggest that 30 million Americans have used cocaine at some point in their lifetime and that 10 million Americans are cocaine dependent and use it regularly.[1] As of 1986, emergency room visits and admissions for cocaine-related incidents had increased 15 fold.[2] Approximately 1700 cocaine-induced deaths were reported for the United States in 1987.[3] These deaths were reported from throughout the country, including the Commonwealth of Kentucky.

We examined the management and outcome of the patients presenting to our teaching hospital with acute cocaine poisoning. A review of the current recommended supportive and pharmacological treatments is presented.

Methods and Observations

All patients treated at the Humana Hospital-University of Louisville for acute cocaine poisoning during the period from January 1, 1985, to January 1, 1989, were identified by computer retrieval of medical records. The intensive care logs were also monitored for critical care admissions or transfers of patients with cocaine-related problems who may not have presented to our emergency room.

A significant trend of increasing emergency room visits and hospital admissions was observed. Thirty-seven patients were treated for cocaine overdose during the interval examined. Females constituted 45% of the group; males accounted for 55%. The mean age for the entire group was 32.0 years. There was no significant difference in the mean age of the females (31.6 years) and that of the male patients (32.1 years). The preferred route of cocaine administration was equally distributed between nasal or intravenous cocaine until 1988. At this juncture, a preference for smoking crack cocaine (47%) could be seen compared to nasal inhalation (21%) and intravenous administration (32%).

Twenty-six patients (70%) were assessed and treated in the emergency area with psychiatric follow-up. Eleven patients (30%) were admitted to the hospital for medical problems. Intubation and mechanical ventilation was required for respiratory failure in five patients. Rhabdomyolysis occurred in three patients, one of whom required dialysis. One patient was admitted with anginal pain and ventricular ectopy. A diagnosis of myocardial infarction was not confirmed. Two patients were admitted after presenting to the emergency room and identifying themselves as "body packers." Neither individual displayed signs or symptoms of cocaine toxicity. Both patients were able to easily pass the packets of cocaine with gentle stool softening and catharsis, thereby

avoiding surgery. One patient who suffered a subarachnoid hemorrhage that was temporally related to cocaine ingestion died while on mechanical ventilation.

Discussion

Cocaine is a naturally produced alkaloid substance that can be isolated from the plant Erythroxylon coca. Its use can be traced back to the ancient Incan civilization in 600 A.D. In the United States, the substance enjoyed popularity at the turn of the century as an additive to patent medicines and as the secret ingredient of a soft drink which still bears reference to the coca plant. Medical use as a topical anesthetic and vasoconstrictor is well chronicled. Currently, however, therapeutic usage as a topical anesthetic is limited by its narrow "therapeutic window" and its known addictive properties.

The major pharmacologic action of cocaine is its ability to block re-uptake of the neurotransmitters norepinephrine and dopamine at the presynaptic nerve terminal. These substances are then available in greater than normal concentrations at the postsynaptic receptors where they effect prolonged stimulation or continued restimulation.[1] The signs and symptoms of cocaine toxicity are both central and peripheral effects, similar to those seen with amphetamine abuse or a catecholamine surge.

Cocaine is rapidly metabolized by the pseudocholinesterase enzymes in the plasma and the liver. The inactive water soluble metabolites are excreted in the urine.[1] Therefore, individuals with preexisting liver or renal dysfunction are considered at increased risk of experiencing the toxic effects of cocaine.

The majority of deaths from cocaine overdose result from seizures, cardiovascular dysfunction, or respiratory failure.[1] Most commonly, fatal cocaine poisoning follows a rapid pattern of convulsions and death within 2 to 3 minutes of ingestion. Occasionally, death may be delayed for 30 minutes or more. On the other hand, if a patient can survive the first 3 hours of a severe episode, he is likely to recover.[4] The clinician must recognize the nature of the multisystemic sympathomimetic response, be alert for special problems that occur in specific situations, and be prepared to provide cardiopulmonary support during this crucial interval.

CNS stimulation from cocaine starts at the cortical level and progresses downward to the medullary centers that control respiration, cardiovascular function, and heat control.[5] This results initially in a subjective euphoria and sense of well-being. As toxicity occurs, euphoria may give way to agitation and restlessness. Grand mal seizures may occur because cocaine significantly lowers the individual's seizure threshold. CNS depression commonly follows the initial euphoria, while delirium, psychosis, or coma may occur after toxic exposure. Continued use of cocaine may lead to brain dopamine depletion at the transmitter storage site. This is felt to contribute to the physiologic and psychologic craving syndrome.[1]

Particularly troubling for the clinician is the intense vasoconstriction that occurs in the CNS vasculature during cocaine ingestion. This response is one mechanism that leads to cerebral ischemia and infarction, as well as increasing the potential for subarachnoid hemorrhage.[6] Cerebral vascular accidents may also result from peripheral vasoconstriction resulting in a transient hypertensive crisis. Intravenous diazepam remains the treatment of choice for cocaine-induced sei-

zures. Psychosis is generally responsive to haloperidol 5 mg administered at hourly intervals for three doses.

The cardiovascular system is a major target in cocaine abuse. Increases in heart rate and oxygen consumption are expected. Patients generally present with tachycardia and often complain of palpitations. Acute myocardial infarction has occurred during cocaine abuse, even in young individuals without significant coronary artery occlusions. The proposed mechanism of myocardial ischemia and infarct is cocaine induced coronary artery vasospasm.[7]

Recent studies also demonstrate a direct effect on the myocardium that results in necrosis. This myocarditis is characterized by an infiltration of the myocardium by eosinophils and an intense vasculitis. The concomitant decrease in cardiac contractility is variable, but may result in permanent global hypokinesis or akinesis.[8]

Cocaine predisposes to cardiac arrhythmias because of enhanced stimulation of beta-1 receptors. Although sinus tachycardia is the most commonly documented arrhythmia, ventricular tachycardia and fibrillation have been reported.[9,10]

Hypertension may be a significant feature of the patient's presentation, but usually is a transient phenomenon that is often followed by hypotension. The clinician, therefore, needs to temper any enthusiasm to use aggressive antihypertensive therapy. The hypotension generally responds to the intravenous administration of isotonic fluids. Only rarely will vasopressors such as dopamine be required.

The administration of propranolol has been advocated in the treatment of the cocaine related emergency because it can provide antiarrythmic, antianginal, and antihypertensive action. Its efficacy in this situation is well documented.[11] Its empiric use, however, deserves a cautionary note. Beta-1 and beta-2 receptor blockade by propranolol may occur resulting in unopposed alpha receptor stimulation with worsening hypertension.[12] This cautionary observation aside, intravenous propranolol given as 1 mg boluses (not to exceed 6-8 mg total) significantly attenuates the physiologic responses induced by cocaine.[13]

As the use of inhaled crack cocaine has increased, the number of pulmonary complications attributed to cocaine has also risen. Initial stimulation of the respiratory drive with hyperventilation may be followed by hypoventilation and hypercarbia with respiratory acidosis. Respiratory failure has also been associated with a form of noncardiogenic pulmonary edema.[14]

Since respiratory failure in cocaine overdose is an expression of medullary center depression, it is considered a preterminal event with poor prognosis. Intubation and mechanical ventilatory support are often required. High fractions of inspired oxygen and positive end expiratory pressure (PEEP) are commonly required. The direct injury to the lungs can be manifested in survivors as a decrease in diffusion capacity and bronchiolitis obliterans.[14]

Intentional oral ingestion of cocaine may produce the euphoric mood previously discussed, but compared to other routes of administration has less of an effect because cocaine is rapidly hydrolyzed in the stomach and is less toxic. Absorption of the drug through the gastric mucosa provides the user with a slower onset of euphoria. Therefore, the oral route is infrequently chosen by regular users. "Body packers" are individuals who ingest cocaine that has been sealed in small balloons for purposes of illegal transport. The cocaine is reclaimed when the balloons are passed with the stool. Massive overdose and rapid cardiovascular collapse occurs when such a balloon ruptures and allows the cocaine to be absorbed through the gastrointestinal tract. A less dramatic but equally grave situation may present if the drug leaches through the container causing a slower onset of cocaine toxicity that is frequently accompanied by intestinal ischemia. Drug-induced intestinal ischemia may also occur when an individual orally ingests cocaine in an effort to avoid arrest when confronted by the authorities.

The clinician should also be aware that "body packers," who are aware of these dangers, may present in panic to the emergency room with psychogenic hyperventilation and palpitations. Unfortunately, surgery may be the only safe method of removing unstable or fragile balloons that contain life-threatening doses of cocaine. The decision regarding surgical intervention vs catharsis can be problematic and appears to depend significantly on the clinician's appraisal of the stability of the container.[15]

The clinician who must care for an active "body packer" should also be aware of the potential for personal injury and breach of hospital security by the "clients" of the transporter who remain interested in securing their investment. There have been reports of balloons being harvested from "body packers" who were slow to

pass the parcels after reaching their destination.

Cocaine induces vasoconstriction in the muscles, generalized sphincter spasm, and central hyperthermia, all of which my result in muscle necrosis. Although most commonly seen in the cocaine overdose patient who seizes, rhabdomyolysis may be significant.[16] Hydration and alkalinization of the urine are protective. Dialysis has been required for acute renal failure at our institution as well as others.

Because cocaine increases uterine muscle contraction, pregnant females who ingest cocaine are at increased risk for abruptio placenta with premature labor. It is also observed that pregnant females have a relatively low plasma cholinesterase activity and may be at increased risk for systemic toxicity as well.

The intent of this review is to provide the clinician with the information needed to correctly assess and manage the victims of cocaine overdose. We must acknowledge, however, that the rapidity with which the acute toxic cocaine reaction occurs limits the number of individuals able to seek medical help. This also limits the effectiveness of the physician's intervention.

There is no antidote known to counteract the effects of cocaine. Because most deaths are a result of seizures, cardiac arrhythmias, and respiratory failure, priority is given to establishing good cardiovascular and respiratory support. Specific recommendations involving pharmacologic agents depend on the organ system disturbed. The pharmacologic treatment during rehabilitation is vast, sometimes experimental, and must be individualized.[17] Psychiatric consultation appears mandatory for the chronic user to help plan the initiation of abstinence and prevent relapse.

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"Okay, so I know I need iron. Where do I get it?"

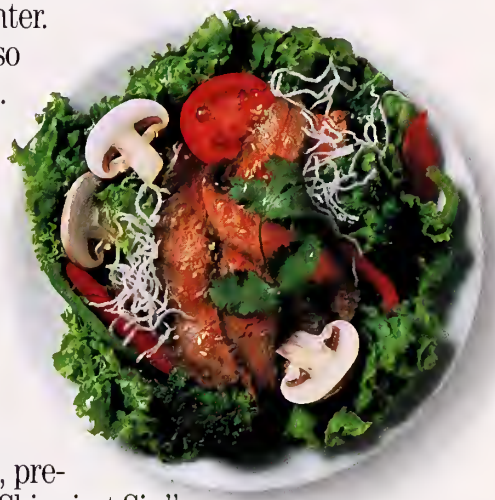
Faced with a Recommended Dietary Allowance of 15 mg, the question is a good one for women aged 19-50. Iron is one of the nutrients most often lacking in the American diet. Low intakes of iron over prolonged time can lead to iron deficiency anemia.

In the 1986 USDA Continuing Survey of Food Intakes by Individuals[1], women of child-bearing years reported a mean intake of 1588 calories a day. Since the American diet averages about 6-7 mg of iron per 1000 calories, it's not surprising that the same survey found that most of these women are getting about 70 to 73 percent of their 1989 RDA for iron.

Yet consider, one three-ounce serving of lean sirloin contains 2.8 mg of iron, about forty to sixty percent of which is heme iron, the most bioavailable form. In addition, the presence of beef or other meats in a meal increases the bioavailability of nonheme iron from foods such as vegetables and grains.

Importantly, lean beef can also meet fat and cholesterol guidelines of most leading heart and health authorities. The how-to's are good advice for almost anyone.

Start with "The Skinniest Six" shown below. None is more than 180 calories per three-ounce cooked, trimmed serving. All are easy to specify at the meat counter.



These six cuts also simplify portion control. Four ounces uncooked equals about three ounces cooked. Grilling, broiling and roasting add no extra fat in cooking. And the taste of beef makes it easy to dispense with fat-laden sauces.

Carefully chosen, prepared and served, "The Skinniest Six" provide an impressive list of essential nutrients for under 180 calories per three-ounce serving.

And as part of a specific plan to increase dietary iron, in a balanced diet beef can be one of the best-tasting recommendations you'll ever make.

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*"The Skinniest Six"**

Eye of Round	*Round Tip*	*Top Loin*	*Top Round*	*Sirloin*	*Tenderloin*
1.65 mg iron	*2.50 mg iron*	*2.10 mg iron*	*2.45 mg iron*	*2.85 mg iron*	*3.05 mg iron*
155 calories	*162 calories*	*172 calories*	*162 calories*	*177 calories*	*174 calories*
5.5 g total fat	*6.4 g total fat*	*7.6 g total fat*	*5.3 g total fat*	*7.4 g total fat*	*7.9 g total fat*
(2.1 g saturated fat)	*(2.3 g saturated fat)*	*(3.0 g saturated fat)*	*(1.8 g saturated fat)*	*(3.0 g saturated fat)*	*(3.1 g saturated fat)*
59 mg cholesterol	*69 mg cholesterol*	*65 mg cholesterol*	*72 mg cholesterol*	*76 mg cholesterol*	*72 mg cholesterol*

Uncooked whole cuts are shown for purpose of identification.

Composite of cooked retail cuts of beef*

Protein	25.9 g
Iron	2.7 mg
Zinc	6.0 mg
Vitamin B-12	2.28 mcg
Thiamin	.08 mg
Niacin	3.6 mg
Sodium	55 mg
Total Fat	8.7 g
(Saturated Fat)	(3.4 g)
Cholesterol	76 mg
Calories	189

1. United States Department of Agriculture, "Nationwide Food Consumption Survey, Continuing Survey of Food Intakes by Individuals. (NFCS, CSFII)" Report No. 86-1. *Nutrients in 3 oz. trimmed and cooked: USDA Handbook 8-13, Rev 1986.

Clinical Study of Keratoconus in Central Kentucky

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Keratoconus is an ectatic corneal disorder that results in a central or inferior conelike anterior protrusion. This results in irregular myopic astigmatism, causing considerable visual impairment. We have completed a retrospective clinical study of keratoconus in the central Kentucky area. When compared to other national studies of keratoconus, our study patients generally had more severe disease at the time of diagnosis and had a higher rate of keratoplasty. Keratoconus treatment is highly successful, and early diagnosis is warranted to prevent unnecessary visual loss.

Introduction

Keratoconus is a noninflammatory conical anterior protrusion of the central or inferior paracentral cornea that is further characterized by central corneal thinning, increasing irregular myopic astigmatism, and occasional corneal scarring associated with acute hydrops. In a 1961 study of 600 keratoconus cases, Amsler found that the vast majority of keratoconus patients are affected bilaterally although the progression is variable and often asymmetrical.[1] Keratoconus displays no known race or sex prevalence and occurs with peak incidence in the 15 to 34 age group (median 25 years) according to Kennedy et al in a 48-year retrospective study.[2] The etiology remains unclear despite recognition of some familial tendencies and circumstantial associations with frequent eye rubbing, previous hard contact lens wear, some systemic collagen disorders, and allergic conditions. The natural history of this disorder is quite variable. The ectasia may slowly progress for 5 to 10 years and then stabilize permanently, or there may be alternating periods of progression and stabilization. There are also cases of minimal change keratoconus often termed "forme fruste" in which the corneal changes remain stationary after their initial identification. Progression of the corneal ectasia rarely occurs after 40 years of age.

As the conical protrusion advances, visual acuity is diminished due to a high degree of irregular myopic astigmatism, and acute corneal hydrops (stromal edema secondary to breaks in Descement's membrane) may ocurr and is associated with residual corneal scarring. Therapy is based upon the severity of the disorder including spectacles for mild astigmatism, contact lenses for moderate to severe keratoconus, and penetrating keratoplasty for patients unable to receive satisfactory results from contact lens wear. When our study was performed, the advanced design contact lenses, which some studies found to decrease the need for penetrating keratoplasty, were not yet developed and consequently were not considered a potential therapy.[3, 4]

The purpose of this study was to retrospectively evaluate keratoconus patients in the central Kentucky region in order to identify characteristics of those patients who eventually underwent penetrating keratoplasty. Primary attention was focused on the occurrence of acute hydrops and the use of contact lenses among keratoconus patients. A comparison based on these factors was made between patients requiring keratoplasty and those not requiring corneal transplantation.

Materials and Methods

Our study group consisted of 39 patients who presented with keratoconus to 12 central Kentucky ophthalmologists between 1969 and 1988. Four patients had been diagnosed with keratoconus prior to 1969. The critieria for diagnosis of keratoconus included: (1) irregular mires detected at keratometry, (2) the characteristic irregular red reflex with a ring-shaped pupillary light reflex due to increased posterior concavity of the

Fig 1 — Munson's sign.

cornea, and (3) an irregularly irregular astigmatism. One of the following must also be present: corneal thinning, at least one diopter of inferior corneal steepening, Munson's sign, or a Fleischer ring. Munson's sign is a V-shaped conformation of the lower lid produced by the ectatic cornea in down gaze (Fig 1). A Fleischer ring is a corneal pigment epithelial ring that partially or completely encircles the base of the cone.

For this study, each patient's course was followed from 1969 through 1988 with the exception of two patients (5%) who died of unrelated causes an average of 37 months prior to 1988. Patients requiring penetrating keratoplasty for keratoconus were identified through records of the University of Kentucky eye bank, and those not requiring corneal transplantation were identified by patient diagnosis from records of the Department of Ophthalmology at the University of Kentucky. Records were examined for comparison of clinical characteristics of the two patient groups. Age, sex, bilaterality of diagnosis, the occurrence of acute hydrops, and contact lens wear were variables compared between the two groups.

Results

There were a total of 39 patients included in the study. Twenty of 39 (51%) patients were female and 19 of 39 (49%) were male. The mean age at diagnosis was 26 years with a range of 9 to 88 years. Their disease was bilateral at the time of diagnosis in 33 of 39 (85%) patients. The severity of the keratoconus at initial diagnosis could not be ascertained from available records. The patient follow-up period lasted an average of 64 months with a range of 16 to 125 months.

Ten of 39 (26%) patients did not require corneal transplantation, while 29 of 39 (74%) patients eventually required keratoplasty (Table I). Compared to the nonsurgical group, patients undergoing keratoplasty were younger at diagnosis (25 years), primarily female (62%), and had bilateral disease (97%). Transplants were performed at an average age of 32 years. Of note, 12 of 29 (41%) of these patients eventually had keratoplasties performed on their fellow eyes. Of the nonsurgical group the majority were males (80%), and only 8 of 10 (80%) showed evidence of bilateral keratoconus. Table I also demonstrates a higher incidence of hydrops and contact lens wear among patients who required keratoplasties.

The significance of hydrops and contact lens

TABLE I Characteristics of Study Patients
n=39

	(-) PK	(+) PK
Number of Patients	10	29
Avg Age at Diagnosis	28	25
Male	8(80)	11(38)
Female	2(20)	18(62)
Bilateral Keratoconus	8(80)	28(97)
Hydrops	2(20)	11(38)
Contact Lens Wearer	6(60)	26(90)
Bilateral PK	-	12(41)

PK = Penetrating Keratoplasty
(x) = Percent of Patients

TABLE II Hydrops vs Contact Lens Use in Keratoconus

	Contact Lens		Hydrops	
	(-)	(+)	(-)	(+)
Number of Patients	7	32	26	13
Avg Age at Dx	30	25	25	23
Male	5(71)	14(44)	16(61)	3(23)
Female	2(29)	18(56)	10(39)	10(77)
PK	2(29)	26(81)	18(69)	11(85)
Avg Age at PK	32	29	34	28

PK = Penetrating Keratoplasty
(x) = Percent of Patients

wear is revealed in Table II. Ten of 13 (77%) hydrops patients were female, while 16 of 26 (61%) patients without hydrops were male. Hydrops also correlated to an earlier age of diagnosis (23 years). Eleven of 13 (85%) hydrops patients underwent keratoplasty compared to 18 of 26 (69%) patients without hydrops. Patients with hydrops had keratoplasty an average of 6 years before patients without hydrops. Most keratoconus patients (82%) wore contact lenses to correct visual problems caused by the corneal irregularities. If contact lenses were worn, diagnosis was usually made 5 years earlier (25 vs 30). If a keratoconus patient did not wear contact lenses, they were probably male (71%) and were less likely to require keratoplasty (29% vs 81%).

Discussion

The keratoconus patients included in this retrospective study were relatively similar to a composite of those in previous studies. Males and females were equally affected, but females were more likely to wear contact lenses, experience an increased incidence of hydrops, and were more likely to have a penetrating kerotoplasty than their male counterparts. No attempt was made to determine prevalence rates of keratoconus in the central Kentucky region since the population for the referral area was not known. The fact that the great majority (74%) of keratoconus patients in this study required penetrating keratoplasty is in contrast to the low percentage (14%) of patients undergoing transplantation reported in the 1986 study by Kennedy et al.[2] This may reflect discrepancies in follow-up or differences in diagnostic acumen. Patients tended to present with more advanced disease in our study than in other studies, as evidenced by the high percentage of bilaterality (92%) and incidence of acute hydrops (33%) among our study patients. The patients undergoing keratoplasty in our study exhibited a higher percentage of bilateral disease (97%) at the time of diagnosis when compared to keratoconus patients in the 1986 study by Kennedy et al (59%). Eighty-five percent of patients with hydrops underwent keratoplasty, whereas 69% of patients without hydrops did not.

The advanced disease at time of presentation may be due to delay on the patient's part in seeking medical attention or due to undetected progression of disease prior to diagnosis on the physician's part. Gradual progression of keratoconus may not be noticed by the patient until visual acuity is significantly reduced thereby prompting the patient to seek medical care. Likewise, an episode of acute hydrops or bilaterality of disease would probably make the patient aware of the ocular abnormality, causing him or her to seek medical attention.

The high percentage of contact lens wear among our keratoplasty patients (90%) may lead one to conclude that contact lenses are detrimental to keratoconus patients. However, contact lens usage is increased because of the inability of patients with more advanced keratoconus to obtain usable vision with spectacles. Contact lens induced corneal changes can be confused with the simultaneous development of true keratoconus in contact lens wearers, but the major difference between the two is that contact lens induced corneal topographical change and the resultant astigmatism is reversible after discontinued lens wear, but true keratoconus corneal changes are not reversible.[5]

Penetrating keratoplasty is the most common surgical procedure used to treat keratoconus and provides excellent visual results. This study suggests that patients with keratoconus may not be diagnosed until late in the course of their disease. Physicians should recognize early signs and syptoms of keratoconus, and referral to an ophthalmologist should be made if questions exist. With early diagnosis of keratoconus, useful vision can be obtained with contact lenses, and the patient

can be saved from the frustration and expense of multiple glasses and poor visual acuity.

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Interactions
A Medical Staff Leadership Program

November 29, 1990
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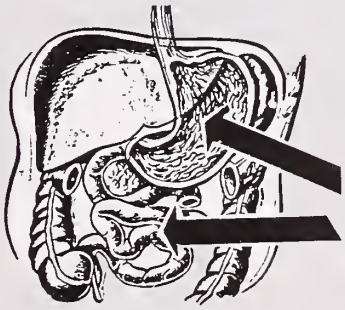

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1. Data on file, G.D. Searle & Co. **2.** 1988 Joint National Committee: The 1988 report of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med* 1988;148:1023-1038.

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Contraindications: Severe LV dysfunction (see *Warnings*), hypotension (systolic pressure < 90 mm Hg) or cardiogenic shock, sick sinus syndrome (if no pacemaker is present), 2nd- or 3rd-degree AV block (if no pacemaker is present), atrial flutter/fibrillation with an accessory bypass tract (eg, WPW or LGL syndromes), hypersensitivity to verapamil.

Warnings: Verapamil should be avoided in patients with severe LV dysfunction (eg, ejection fraction < 30%) or moderate to severe symptoms of cardiac failure and in patients with any degree of ventricular dysfunction if they are receiving a beta-blocker. Control milder heart failure with optimum digitalization and/or diuretics before Calan SR is used. Verapamil may occasionally produce hypotension. Elevations of liver enzymes have been reported. Several cases have been demonstrated to be produced by verapamil. Periodic monitoring of liver function in patients on verapamil is prudent. Some patients with paroxysmal and/or chronic atrial flutter/fibrillation and an accessory AV pathway (eg, WPW or LGL syndromes) have developed an increased antegrade conduction across the accessory pathway bypassing the AV node, producing a very rapid ventricular response or ventricular fibrillation after receiving I.V. verapamil (or digitalis). Because of this risk, oral verapamil is contraindicated in such patients. AV block may occur (2nd- and 3rd-degree, 0.8%). Development of marked 1st-degree block or progression to 2nd- or 3rd-degree block requires reduction in dosage or, rarely, discontinuation and institution of appropriate therapy. Sinus bradycardia, 2nd-degree AV block, sinus arrest, pulmonary edema and/or severe hypotension were seen in some critically ill patients with hypertrophic cardiomyopathy who were treated with verapamil.

Precautions: Verapamil should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of overdosage. Verapamil may decrease neuromuscular transmission in patients with Duchenne's muscular dystrophy and may prolong recovery from the neuromuscular blocking agent vecuronium. It may be necessary to decrease verapamil dosage in patients with attenuated neuromuscular transmission. Combined therapy with beta-adrenergic blockers and verapamil may result in additive negative effects on heart rate, atrioventricular conduction and/or cardiac contractility; there have been reports of excessive bradycardia and AV block, including complete heart block. The risks of such combined therapy may outweigh the benefits. The combination should be used only with caution and close monitoring. Decreased metoprolol clearance may occur with combined use. Chronic verapamil treatment can increase serum digoxin levels by 50% to 75% during the first week of therapy, which can result in digitalis toxicity. In patients with hepatic cirrhosis, verapamil may reduce total body clearance and extrarenal clearance of digitoxin. The digoxin dose should be reduced when verapamil is given, and the patient carefully monitored. Verapamil will usually have an additive effect in patients receiving blood-pressure-lowering agents. Disopyramide should not be given within 48 hours before or 24 hours after verapamil administration. Concomitant use of flecainide and verapamil may have additive effects on myocardial contractility, AV conduction, and repolarization. Combined verapamil and quinidine therapy in patients with hypertrophic cardiomyopathy should be avoided, since significant hypotension may result. Concomitant use of lithium and verapamil may result in a lowering of serum lithium levels or increased sensitivity to lithium. Patients receiving both drugs must be monitored carefully. Verapamil may increase carbamazepine concentrations during combined use. Rifampin may reduce verapamil bioavailability. Phenobarbital may increase verapamil clearance. Verapamil may increase serum levels of cyclosporin. Concomitant use of inhalation anesthetics and calcium antagonists needs careful titration to avoid excessive cardiovascular depression. Verapamil may potentiate the activity of neuromuscular blocking agents (curare-like and depolarizing); dosage reduction may be required. Adequate animal carcinogenicity studies have not been performed. One study in rats did not suggest a tumorigenic potential, and verapamil was not mutagenic in the Ames test. Pregnancy Category C. There are no adequate and well-controlled studies in pregnant women. This drug should be used during pregnancy, labor, and delivery only if clearly needed. Verapamil is excreted in breast milk; therefore, nursing should be discontinued during verapamil use.

Adverse Reactions: Constipation (7.3%), dizziness (3.3%), nausea (2.7%), hypotension (2.5%), headache (2.2%), edema (1.9%), CHF, pulmonary edema (1.8%), fatigue (1.7%), dyspnea (1.4%), bradycardia: HR < 50/min (1.4%), AV block: total 1°,2°,3° (1.2%), 2° and 3° (0.8%), rash (1.2%), flushing (0.6%), elevated liver enzymes. The following reactions, reported in 1.0% or less of patients, occurred under conditions where a causal relationship is uncertain: angina pectoris, atrioventricular dissociation, chest pain, claudication, myocardial infarction, palpitations, purpura (vasculitis), syncope, diarrhea, dry mouth, gastrointestinal distress, gingival hyperplasia, ecchymosis or bruising, cerebrovascular accident, confusion, equilibrium disorders, insomnia, muscle cramps, paresthesia, psychotic symptoms, shakiness, somnolence, arthralgia and rash, exanthema, hair loss, hyperkeratosis, macules, sweating, urticaria, Stevens-Johnson syndrome, erythema multiforme, blurred vision, gynecomastia, increased urination, spotty menstruation, impotence.

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Psychosocial Aspects of Alzheimer's Disease

David A. Casey, MD; Karen Robinson, DNS, RN

November is national Alzheimer's disease month. This disorder involves not only cognitive dysfunction but also psychiatric symptoms. Alzheimer's disease places a tremendous burden on caregivers. These psychosocial factors are often the causes of institutionalization.

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Alzheimer's disease (AD) is the most common cause of dementia. As the elderly make up an ever-increasing percentage of the population of the United States, AD will become one of the nation's major public health problems. Recent studies suggest that as many as 10% of persons over age 65 suffer from AD or a related disorder. This means that in Kentucky, a state with approximately 3.6 million people of whom about 360,000 are over 65, as many as 36,000 have dementia. The cost of caring for demented patients is enormous. Nationwide, the cost of nursing home care for demented patients has been estimated at $23 billion. However, many AD patients are cared for at home, particularly in the early stages of the disease. Obviously, the costs of providing home care are dramatically lower. A number of studies have shown that the decision to place an AD patient in a nursing home is more heavily influenced by the presence of psychiatric symptoms or problem behaviors than by loss of memory and other cognitive functions.[1] In this paper we will examine these psychiatric and social factors which affect the care of the AD patient. November is national Alzheimer's disease month, when consideration of these topics is especially appropriate.

Psychiatric Syndromes in AD

In his original case description, Alzheimer described not only cognitive symptoms such as memory loss, aphasia, and apraxia but also noncognitive symptoms including delusions and agitation. Research on AD has focused almost exclusively on etiology, pathogenesis, and treatment of the cognitive dysfunction. As yet this has not produced any clinically effective therapies, although many promising avenues are being investigated. Almost no research has been done on treatment of the psychiatric complications of AD, though such treatments are regularly given on an empirical basis.[2]

Problem behaviors in AD are many and varied. They include wandering, irritability, noisiness, combativeness, insomnia, and resisting caretaking efforts. These behaviors vary greatly from patient to patient and may make home care impossible. These behaviors do not necessarily correlate directly with degree of cognitive dysfunction. However, they are often related to the presence of a psychotic state including delusions and hallucinations. Such psychotic symptoms are common in AD. In one study of nursing home patients, 22 of 56 AD patients (39%) had psychotic symptoms.[3]

Educating physicians about the needs of caregivers of persons with dementia is necessary because many physicians underestimate the impact of caring for a person with dementia.

Depression is also common in AD. Several studies suggest that about 17% to 20% of AD patients meet criteria for major depression. Depressed patients are more disabled and may have more cognitive dysfunction than other AD patients. Depression is probably even more common in patients who suffer from multi-infarct dementia. Depression may be a source of treatable

"excess disability" in AD.[4] Severe depression in the elderly may sometimes mimic the symptoms of AD, leading to misdiagnosis and missed opportunity for treatment. This syndrome is sometimes known as pseudodementia. As compared to AD patients, pseudodementia patients are more likely to have a previous history of depression, family history of depression, rapid decline, depressed affect, and thoughts of death, suicide and hopelessness. Pseudodementia patients may complain bitterly of memory loss rather than deny or minimize the problem, as is more typical in dementia. Their objective memory impairment is often modest and inconsistent, with poor effort, concentration, and attention being present. AD patients typically have a gradual insidious downhill course and may display a wide range of deficits on mental status testing, especially as the disease progresses. Neurologic indicators of "organicity" such as aphasia, agnosia, and apraxia may develop as well as the "sundowning" syndrome. Some cases may be impossible to distinguish. In such cases an empirical trial of treatment for depression may be indicated. Some researchers believe that the concept of pseudodementia is somewhat misleading and that such patients often eventually develop true AD.[5]

A number of studies have shown that the decision to place an AD patient in a nursing home is more heavily influenced by the presence of psychiatric symptoms or problem behaviors than by loss of memory and other cognitive functions.

AD patients eventually lose the ability to communicate with others about their internal experiences. They may respond in similar ways to a wide variety of different stimuli. For instance, agitation may be a response to a physical illness, pain, a distressing psychotic symptom, or to social or interpersonal conflict. For this reason, response to symptoms such as agitation requires an individual assessment rather than reflexive prescription of medication. Changes in the environment may be needed. Pharmacologic treatment of psychiatric syndromes has been hampered by the lack of research in this area. Medication regimens are often based on clinical lore. Some studies have suggested that psychotropic medications are overutilized in nursing home populations. However, given the very high incidence of psychiatric disorders in nursing homes, the problem may not be one of overuse per se, but rather inexpert use of psychotropic medications. As the field of geriatric psychiatry grows, psychiatric consultation to nursing homes may help alleviate this problem. In general, patients with psychotic syndromes require treatment with antipsychotic medication. Low doses are advised, though there is tremendous variability of response and tolerance from patient to patient. High potency neuroleptics such as haloperidol generally lead to the fewest side effects. Unfortunately, the elderly are prone to side effects with these as with all medications and must be closely monitored. Pseudoparkinsonism, akathisia (motor restlessness), and with long-term use, even tardive dyskinesia may occur. Cardiovascular symptoms, especially orthostatic hypotension, are more likely with low potency neuroleptics such as chlorpromazine. When patients receiving such medications develop new adverse behaviors, one must always consider a medication reaction. An analysis of risk versus benefit is a useful way to approach neuroleptic prescription. In general, informed consent has been held to be important in prescribing such medications. This presents obvious difficulties in AD which can be addressed by involvement (and documentation) of families or other guardians. When antipsychotic medication is ineffective, poorly tolerated, or when agitation is not clearly associated with psychosis, a variety of other medications may be utilized such as benzodiazepines or propranolol, depending on the individual case. When benzodiazepines are chosen, those with short half-lives and few metabolites such as oxazepam, lorazepam, or alprazolam are generally preferred. Longer lived drugs such as diazepam may accumulate and are more likely to cloud consciousness and impair gait. In AD with depression, antidepressant medication is generally believed to be useful. Tricyclic antidepressants are the best studied but have the disadvantage of being anticholinergic. Memory loss in AD involves loss of cholinergic neurons, and anticholinergic medications may exacerbate this

effect. Tricyclics with the lowest anticholinergic effect include nortriptyline and desipramine. Other antidepressants such as trazodone, fluoxetine, and bupropion are much less anticholinergic but have not been well studied in AD.[6]

Effects of Caregiving

Caregivers of AD victims represent a high risk population for physical illness, mental illness, and financial costs.[7-11] Because caregiving for an AD victim is time-consuming, frustrating, and often a thankless task, caregivers become fatigued, depressed, angry, and isolated. The caregiving experience has the greatest impact in the area of social activities and mental health.[12]

Cantor (1983) identified wives as the highest risk group among caregivers because they have lower household incomes, are often older and more infirmed, and are often living without a child at home to assist with caregiving. Wives of demented husbands are in double jeopardy because they live with a loved one who looks the same but indeed is not the same person they married.[13] Wives grieve, therefore, for the loss of a companion who remains physically present, yet requires increased physical care as deterioration increases.[14]

Almost no research has been done on treatment of the psychiatric complications of AD, though such treatments are regularly given on an empirical basis.

In a study of 78 wives who served as primary caregivers to husbands with irreversible memory impairment, wives were found to be a depressed population because the mean in this sample of caregivers was higher than the cutoff for depression recommended by Himmelfarb and Murrell (1983) as reflecting need for professional intervention for older adults.[11, 15] The relationship of caregiver health, past marital adjustment, and received social support to depression was studied. In addition, socioeconomic status and attitudes toward seeking help were investigated. Only caregiver poor health and a negative attitude toward asking for help were significant predictors of depression.[11]

Despite the burden associated with caregiving, caregivers indicate a desire to care for their loved ones at home as long as possible. Many caregivers are reluctant to seek outside help and supportive services to provide this care and take on huge caregiving responsibilities. Physicians, therefore, need to use clinical interventions which will help caregivers better manage the caregiving experience.

Social support is a concept of great importance in the investigation of ways to aid adjustment to caregiving. This concept refers to interpersonally supportive behaviors and includes the giving and receiving of social support throughout the life course. Zarit et al (1980) found caregiving burden decreased with increased visits to the caregiver by family members and friends.[16] Fengler and Goodrich (1979) reported that children, relatives, and friends who visited became important social supports for high-morale caregiving wives.[17] Thus the social network has been found to play a significant role in stress reduction among caregivers.[8, 12, 18]

Wife caregivers were found to have a negative attitude toward asking for help. Caregivers in one study identified asking for help to be closest to the "slightly bad" category.[11] Attitude of the caregiver toward seeking social support had a significant negative relationship with depression. Caregivers with a positive attitude reported significantly less depression. Spouses generally believe that caregiving is their own responsibility and that they should be able to do it without assistance. This belief seemed to give rise to feelings of failure and dependency when they had to ask for help. The negative attitude toward help may be the result of a view by spouses that caregiving is part of their marital responsibility.[11]

One of the most critical health policy issues to be addressed in the next decade is long-term care for the elderly.[19] The issue of alternatives to hospitalization for the elderly demented victim is of ever-increasing importance. Home care has become an important alternative to institutionalization. Research has demonstrated that when older persons need care, family members are the primary caregivers.[20] Eighty percent of the home

health care of the elderly in the United States is provided by family members. Without this caregiving existing health agencies would be swamped with demands for care. Family help plays a key role in the provision of low cost services for this age group. With growing recognition of the stressful nature of caregiving, a growing research arena has focused on how best to support the lay caregiver. Physicians are key personnel who can intervene with the caregiver at an early stage to encourage the use of support and community resources.

It is hoped that understanding the negative consequences of caregiving expected for the primary caregiver will encourage physicians to provide supportive interventions.

Educating physicians about the needs of caregivers of persons with dementia is necessary because many physicians underestimate the impact of caring for a person with dementia. Assisting families to cope with caring for a person with dementia includes making the period of diagnosis less traumatic by explaining the need for and outcomes of the specific diagnostic procedures; validating the feelings of loss experienced by the family as well as the person with AD; and teaching about the stages and progression of the disease.

Specific interventions have been discussed in the literature and suggested by caregivers. Few who work with diagnosing of AD are used to provide support to the primary caregiver. It is not easy or comfortable for the physician to impart a diagnosis of AD to the family. Physicians often feel nothing can be done about this irreversible illness; therefore, there is no need to see the AD person again. It is hoped that understanding the negative consequences of caregiving expected for the primary caregiver will encourage physicians to provide supportive interventions. In this way physicians can develop and sustain an effective, therapeutic relationship with families who care for persons with AD. Specific interventions are set forth and explored in the list below.

Strategies to Assist Families to Cope With the Diagnosis of AD

1. During the diagnostic period:
   Give clear, continuous information about the purpose of the various diagnostic procedures ordered. Make sure caregivers are aware of the restrictions on eating or drinking that may accompany the diagnostic procedures. Explain the use of medical terminology such as dementia and delirium. Make a continuing assessment of the primary caregiver's understanding of the diagnosis and, later, the expected progression of the disease. Assist family members to offer support to the primary caregiver by asking all family members to be present for the explanations given about AD.
2. Validating the loss:
   Encourage the family to verbalize their feelings of loss; give them verbal and tactile permission to grieve. Be real, share your own feelings of distress and sadness with the family. This is not unprofessional behavior. Be willing and available to talk with the family about the diagnosis and course of the disease.
   Support and encourage the family to participate in the care of the person with AD and in sharing the responsibilities of care during the progression of the disease. Reinforce to the caregiver that expectations to provide ongoing care without assistance are unrealistic. Review community resources which will aid the family in caregiving endeavors. Refer the family to the nearest Alzheimer's Disease and Related Disorders Association (ADRDA) chapter by giving the phone number and purpose of this agency. Encourage family members to attend the support groups and educational meetings offered by the ADRDA Chapter.
3. Teaching families about the progression of the disease:
   Give families anticipatory guidance regarding what they may experience during the progression of the disease. Warn the primary caregiver that they may experience feelings of loneliness, depression, guilt, anger, and irritability. Encourage the caregiver to maintain the activities which they find pleasureable in order to maintain a balance which will keep the caregiver healthy. If the caregiver works and enjoys their occupation, encourage them to maintain

their job. Help the caregiver problem-solve about community resources which may be utilized while the caregiver is at work, ie, adult daycare and, later, in-home respite care.

Health of the caregiver must be maintained. Caregiver poor health was found to be the best predictor of depression.[11] Often the caregiver and physician focus only on health of the AD victim. Needed surgeries and medical procedures for the caregiver are often postponed because of caregiving responsibilities. The caregiver's health must be maintained in order for caregiving to continue. Caregivers must be encouraged to maintain healthy lifestyles. This can be difficult because symptoms exhibited by the AD person (wandering and sleep disturbances) often result in sleeplessness for the caregiver. Interventions which promote sleep for the AD person must be considered so the caregiver can get adequate periods of rest in order to maintain health.

Summary

Alzheimer's disease is a major public health problem, in a large part because of the psychosocial morbidity of the disorder. The psychiatric and social complications of AD often lead to institutionalization. Further research is needed to address these issues. Physicians have an important role to play in supporting caregivers and in appropriately treating the psychiatric complications of AD.

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NOVEMBER

17 — Fluid Resuscitation in the Critically Ill, The Seelbach, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

26 — Dean's Hour — Silas Starr Lecture, University of Louisville, Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

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FEBRUARY

5-10 — Rheumatology for the Practicing Physician, Keystone Resort, CO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110; 800/325-9862, 314/362-6893.

21-24 — Rhinoplasty — Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110; 800/325-9862, 314/362-6893.

Feb-April — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology, Home Study Course A, The Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, 301/955-8594.

MARCH

8-9 – 4th Annual Contact Lens Course, Washington University Medical Center, St. Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110, 800/325-9862 or 314/362-6893.

13-15 — Seventeenth International Symposium on Psychopharmacology, Holiday Inn-Hurstbourne, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

25 — Dean's Hour — W. O. Johnson lecture, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

APRIL

4-5 — Advanced Gynecologic Endoscopy, University of Louisville Health Sciences Center Instructional Bldg, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

11-13 — Treatment of Surgical Spine Disease, The Ritz-Carlton Hotel, St. Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St. Louis, MO 63110, 800/325-9862 or 314/362-6893.

14-25 — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology, In-Residence Course B, The Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, 301/955-8594.

25-27 — High Risk Pregnancy Postgraduate Course, Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

25-26 — 18th Annual Obstetrics and Gynecology Symposium. Washington University Medical Center. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110; 800/325-9862, 314/362-6893.

30-May 2 — Molecular Basis of Bone Cell Physiology: Transcellular Signaling, The Sheraton West Port Inn, St Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110; 800/325-9862, 314/362-6893.

MAY

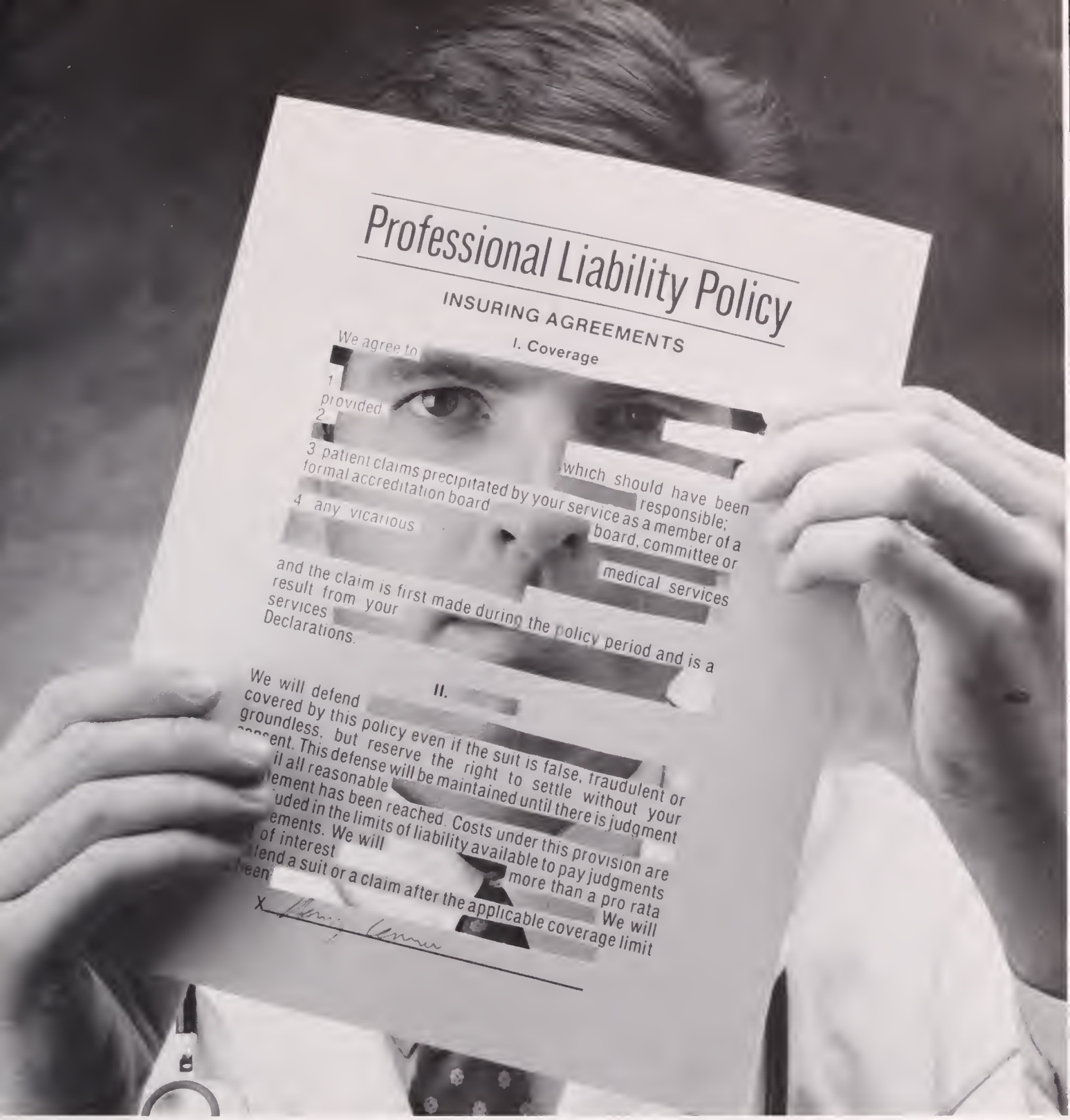
18 — Nephrology Seminar, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

JUNE

17-21 — Thirteenth Family Medicine Review, Hyatt Regency Hotal, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

JULY

20-27 — 9th Annual Medical Seminar at Plummer's Great Slave Lake Lodge, Northwest Territories, Canada. Topics in Contemporary Medicine. All specialties. Category 1 — 23 approved CME credits. Sponsored by North Memorial Medical Center and the University of Minnesota Department of Family Practice and St John's Regional Health Center, Springfield, MO. Contact: 612/588-9478.



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PRO Quality Letters

Recently the Chairman of the PRO Advisory Committee for KMA called the Kentucky Sentinel office and indicated that one of his colleagues had received an adrenalin producing letter indicating a potential level II quality problem. Several other physicians have indicated these letters cause an unnecessary interruption in their busy practice schedules and tend to produce a significant amount of anxiety and stress.

A PRO letter of notification is considered a form of direct communication between attending physicians and our reviewing physicians known as physician advisors. Most notices pertain to necessity of procedures, appropriate admissions, or the questions that may arise about the quality of care. While such notices may cause concern, we want you to understand why we proceed as we do and how you can help by responding to our physician advisors' questions.

The PRO letters of notification are communication tools which are an integral part of the peer review process. These letters are sent to the attending physician when our review coordinators have been unable to certify that the care was necessary and of appropriate quality. Sentinel has been provided the responsibility through a contract with the Health Care Financing Administration to monitor the quality of care provided to our Medicare beneficiaries. The letters contain certain elements required by our contract.

PRO notices are intended to ensure that affected parties are aware of a potential or conclusive determination and that such parties have adequate opportunity to submit additional information or to differ with the determination. The PRO notice also provides the affected party with important information regarding the right of appeal. The formal process of notification of such determinations thus enhances the accuracy of the outcome of review while promoting the quality of care through a process of evaluation and communication.

Each day, Sentinel issues approximately 100 letters to hospitals and physicians in Kentucky. If you should receive a letter from us, you are given 30 days in which to respond to the initial physician advisor's determination or question. We certainly appreciate and understand the investment of your time in responding either via telephone or in writing.

Each response is considered by a physician advisor. We do ask you to assist us when responding by letter. Please indicate the patient's name, hospital, health insurance claim number, admission and/or discharge date, as well as our special identifier batch and form numbers. Your response will be handled more expeditiously with this information. Your responses also provide Sentinel with an opportunity to evaluate and improve our screening and review process.

Sentinel Medical Review Organization
Thomas E. Mangus/Director
Medical Review Services
August 1990

The Far Side of the Helix

David L. Stewart, MD

And now these three remain: faith, hope, and love. But the greatest of these is love. I Corinthians 13:13

This time I'm going to discipline myself. Here is a page that will speak not at all of the frightful things threatening medicine, of the absurdities, inanities, and stupidities that drive our adversaries. This month, in this column there will be no pining for the good old days, no dire predictions, no wistful waiting for the swing of the pendulum back to coherence and order. No negatives, no gloom — there will be time aplenty for that. Instead, in November, let's pause and thankfully gaze at the marvelous complexity of healing, the healing we see daily.

Healing Arts, we call them. Techniques were never so sophisticated as now, but Art can still be the physician's distinctive. So we can be grateful in this month of Thanksgiving for something we'll never understand completely — the nature of healing. Oh, we understand a lot. Enlarging the lumen of a strangled artery can nourish downstream tissues — often. An antibiotic may savage a bacterium's metabolism without doing too much to ours — usually. Borrowed organs or cells can substitute nicely — sometimes. We look with awe on the DNA helix, marveling at what has been deciphered, at the "three billion nucleotide letters that it takes to spell Human Being." But, as Barry Commoner says in commenting on the popular aphorism that DNA is the secret of life, "biology might be more wisely guided by the aphorism 'life is the secret of DNA.' "

One of the things I'm thankful about this month is that we, and even those much wiser than we, will never understand all there is to know about people. We know something of the healing process, but there is ever so much more that we do not, can not know; we will never know it all. What a blessing! What a burden to pretend to know it all!

Generously reminding us of our well-deserved need for humility are the cases that don't fit any rule or experience, the simple illnesses that prove fatal, the massively ill that can't live, but do. How satisfying it is that no patient and no healer is just like another.

Having recently joined the ranks of the unwell (metastatic CA, prostate) I've had some patient-type experiences. I'll spare you the details but it has been illuminating and has given hints of some of the elements that go into modern medicine. I've been called by my first name by bored and busy clerks one-third my age, threatened with a collection agency by a colleague's computer because of a delayed $12 payment (I paid at once!). I've sat in waiting rooms with my fellow patients, some looking quite well, some with pale porcelain skin, veins like cracks in the glaze, with deep, dark eyes and but a few wisps of hair. We've eyed each other silently, furtively, wondering. After a time we've been summoned in to see the doctor and we've wanted and gotten the very best and latest in techniques and experience. But we all, patients and physicians, sense the massive amount we do not know, the absurdity of promises and predictions. So then, on the other side of technique and experience begins the Healing Art. Real physicians are practitioners of this art and when they do we go away with nothing changed but feeling better, sensing care and concern and interest, wondering about inexplicable cures, getting determined, convinced that we're in good hands.

St. Paul was an ignoramus about DNA but he teaches us still about the far side of the helix, he teaches of Faith — a belief in something we've found real, and of Hope — "a poor guide but an excellent companion," and Love, a sovereign preference, and the most important of all. And all three are decidedly contagious. I wish there was a medical school course in Faith, Hope and Love.

I'm thankful in November of 1988 for the things we cannot measure, cannot prove, but still know. I'm thankful for healing that we cannot understand. 1988 is a great year!

***The Journal** is reprinting this editorial from the November 1988 issue in memory of Dr David L. Stewart, who died in November 1989.*

KMA Member . . .
Auxilian . . .

Our readers are interested in the important events occurring professionally in the lives of their fellow members. Do you, or someone you know, have a newsworthy note to submit for possible publication in your *Journal of the KMA?*
If so, please submit in writing to:

KMA Journal
3532 Ephraim McDowell Drive
Louisville, KY 40205

"THANKS" for "GIVING"

Today, in the world of education acceleration, it is enlightening to realize how people help people. A couple of months ago a letter went out from the Health Careers Committee of the Auxiliary asking for donations. The request was made because we had so many needy applicants for our health careers grant who, because of their desire for education, had turned to us for help. The following sent money, and during this month of reflection on *our* blessings, I wish to *thank* them on behalf of the students who are helped by the health careers grants.

Dr & Mrs Robert Goodin, Louisville
Dr & Mrs David Eggers, Utica
Dr & Mrs Bruce Lucas, Lexington
Dr & Mrs Ralph F. Huller, Jr, Crestview Hills
Dr & Mrs Waitman B. Taylor, Owensboro
Dr & Mrs Henry Liau, Hanson
Dr & Mrs B. Sarkari, Paducah
Dr & Mrs Rick D. Isernhagen, Lexington
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Dr & Mrs Michael F. Yeiser, Owensboro
Dr & Mrs Daniel Pickar, Louisville
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Dr Harvey St. Clair, Louisville
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Ms Darrye J. Jackson, Paducah
Dr & Mrs Leslie M. Riherd, Owensboro
Dr & Mrs James Zalla, Burlington
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Dr & Mrs James L. Sublett, Louisville
Ms Suzanne Prough Dozier, Lexington
Dr & Mrs Thomas E. Bunnell, Edgewood
Dr & Mrs William T. Conner, Ashland
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Dr & Mrs Douglas Gossman, Crestwood
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Dr & Mrs John Riehm, Louisville
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Our need continues. As before, your donation would be greatly appreciated.

Happy Thanksgiving!

Betty Schrodt
AKMA President

Highlights of the 1990 KMA Annual Meeting

The Kentucky Medical Association completed its Annual Meeting at the Hyatt Regency Hotel/ Commonwealth Convention Center in downtown Louisville on September 27. Over 2500 physicians and others registered for the meeting, which included two sessions of the KMA House of Delegates. AMA President C. John Tupper, MD, addressed the Second Meeting of the House on Wednesday, September 26.

A capacity crowd attended the President's Luncheon, which highlighted the installation of Preston P. Nunnelley, MD, Lexington, as the 1990-91 President of KMA. The Luncheon also featured the presentation of the Distinguished Service Award to KMA Past President Wally O. Montgomery, MD, of Paducah, for his many years of faithful and devoted service to the Association and the profession.

The House of Delegates elected S. Randolph Scheen, MD, a Louisville dermatologist who had served 24 years as KMA's Secretary-Treasurer, to President-Elect. Dr Scheen will assume the office of President at the 1991 Annual Meeting. Other elections included William B. Monnig, MD, Edgewood, Vice President; and William P. VonderHaar, MD, Louisville, Secretary-Treasurer. Three new Trustees were elected: Joseph E. Kutz, MD, Louisville, 5th District; Mark F. Pelstring, MD, Covington, 8th District; and Paul R. Smith, MD, London, 15th District. Robert R. Goodin, MD, Louisville, was elected Delegate to the AMA, and Wally O. Montgomery, MD, Paducah, was reelected as AMA Delegate. Bob M. DeWeese, MD, Louisville, was elected Alternate Delegate to the AMA, and Ardis D. Hoven, MD, Lexington, was reelected AMA Alternate Delegate. Cecil D. Martin, MD, Carrollton, will serve as Chairman of the Board of Trustees, and Lucian Y. Moreman, II, MD, Elizabethtown, Vice Chairman of the Board.

Highlights of House action included: recognition of Pfizer Roerig, Inc for making its entire product line available to eligible Kentucky Physicians' Care outpatients at no charge; to study the establishment of a centralized database for all prescribed drugs or medications in the Commonwealth of Kentucky for easy access by physicians and pharmacists in the Commonwealth; and encouragement of all Kentucky physicians to actively solicit physicians to run for public office and seek policy-setting positions with third-party payors and insurors.

The House also voted that KMA continue to oppose CON exemptions based on geography, population, and number of acute hospital beds, and that it support the repeal of those exemptions granted to Jefferson County hospitals by the 1990 Kentucky General Assembly; to continue a strong leadership role and firmly pursue all channels necessary to remedy the injustice of inequity in reimbursement by third parties to physicians and hospitals in rural areas, as opposed to urban areas, and that KMA policy should reflect that in the process of instituting single, equitable, statewide reimbursement schedules, insurance companies should not diminish any present reimbursement schedules; to request that Sentinel Medical Review hold group meetings with local physicians to help resolve concerns over frequent laboratory tests; to adopt a policy that Medicaid reimbursement methods should not discriminate against any class or specialty of physicians, that the Department of Medicaid Services and the Cabinet for Human Resources be urged to examine the Medicaid reimbursement policy, and that this policy should reflect reimbursement levels proportionate to charges and level of skill and training, regardless of physician location or specialty; to draft legislation or regulations to standardize Medicare supplement policies issued in Kentucky; and to urge county and city governments throughout the state to develop local seat belt laws.

Other action included a call for a state legislative study on the potential risks of unsafe operation of water jet skis, boats, and alcohol use in water sports, and to provide for regulation of adequate education and operation of the same; and to endorse and encourage Congress to enact HR 467 (commonly known as the Brady Bill gun control law), calling upon Kentucky's Congressional Delegation to support the legislation.

AMA President John C. Tupper, MD, addressed the Delegation concerning the actions of the incumbent Inspector General of the US Department of Health and Human Services, Richard Kusserow, involving the Medicare program. The House voted to join with the AMA in calling for the resignation of Mr Kusserow and to advise the Kentucky Congressional Delegation of this position and seek their assistance in persuading President Bush to ask Mr Kusserow to resign.

The KMA House of Delegates recognized and recorded its deep appreciation for the extraordinary contributions of the late Senator John E. "Jack" Trevey, MD, to his patients,

profession, and community. The House also expressed its gratitude and appreciation to Mr Joe A. Wallace and Ms Cecil Dulin Wallace for bequeathing upon their deaths to KMA the Cambus-Kenneth farm, the summer home of the pioneer surgeon Ephraim McDowell, MD. This valuable and historical gift provides an opportunity for KMA to preserve this segment of history surrounding the life of Dr McDowell. AIDS victim Ryan White, his family, and large circle of friends were commended for accomplishments, contributions, unwavering support, and encouragement manifested during his illness and death. The House resolved that Ryan White's efforts served as a memorial to the triumph of the basic rights of individuals to receive appropriate medical care and social attention, regardless of their malady.

The annual KEMPAC Dinner was also held during the Annual Meeting and was attended by many physicians and their spouses, as well as numerous members of the Kentucky General Assembly. Chairman Randolph D. Smoak, MD, Washington, DC, brought greetings from AMPAC. Senatorial candidates Harvey I. Sloane, MD, and Senator Mitch McConnell addressed the group; Dr Sloane in person and Senator McConnell by speaker-phone.

A full report of the Annual Meeting and actions by the House of Delegates will appear in the December issue of the KMA *Journal*.

kma

To Our Exhibitors and Special Contributors:

For Continued Support and Helping to Make the KMA 140th Annual Meeting a Success ---

THANK YOU!

PEOPLE

Dr Alvin C. Poweleit, Covington, was recently honored at the Ohio Convention of the American Ex-Prisoners of War. Dr Poweleit was given a commendation for his work as Medical Advisor to the American Ex-POWs through the years 1949 to the present.

Prue W. Kelly, MD, Murray, and **William J. Spanos, MD,** Louisville, were named as Fellows of the American College of Radiology during ceremonies at the ACR annual meeting held recently in Nashville, TN. Selected for their outstanding contributions to the field of radiology, these KMA members were among 131 new fellows named by the College's Board of Chancellors.

The University of Louisville School of Medicine has announced the following appointments to its staff: **Thomas Bergamini, MD,** surgery instructor; **Veronnie Jones, MD,** assistant professor of pediatrics; **Cathleen Morris, MD,** instructor in medicine; **George Raque, MD,** assistant professor of surgery; **Robert Zax, MD,** clinical instructor in medicine; **Miguel Ossorio, MD,** assistant professor of medicine; **Manjula Pandit, MD,** assistant professor of medicine.

Benjamin Rigor, MD, anesthesiology chair, was among 35 University of Louisville employees recently chosen to receive 1990 Outstanding Performance Awards. The awards were open to administrators and staff, and were presented based on a candidate's demonstrated commitment to affirmative action, successful plans to boost the number of minority groups represented on campus, programs aimed at meeting the special needs of minority employees, and the ability to provide an atmosphere where affirmative action concerns can be informally resolved. Dr Rigor deserves credit for "developing an atmosphere within the department where equal opportunity, equal respect, and equal responsibility are entwined," wrote his nominator.

UPDATES

Bird's Nest Filter Traps Deadly Clots

The University of Louisville reports that a clot-catching process using x-ray technology enables University of Louisville diagnostic radiologist **Hollis A. Thomas, Jr, MD,** to save lives without the trauma and cost of major surgery.

Guided by a television monitor, Dr Thomas can insert a tiny wire mesh device called a bird's nest filter into a patient's vein via a flexible tube. There the filter can trap clots so they dissolve before reaching the heart or lungs and causing a heart attack or stroke.

US Food and Drug Administration Approval

G. D. Searle and Company has announced that it has received FDA approval to market a 100-mcg dose of Cytotec (misoprostol). It was previously available only in 200-mcg tablets. According to Searle, the most common side effect of Cytotec is diarrhea and using the 100-mcg dose significantly reduces the incidence of diarrhea.

Provider, Payer, and Utilization Review Groups Develop Guidelines for Concurrent Utilization Review

The American Hospital Association, the American Managed Care and Review Association, the American Medical Association, the Blue Cross and Blue Shield Association, and the Health Insurance Association of America have jointly developed voluntary guidelines for the conduct of private utilization review programs. These guidelines are designed to promote consistency and uniformity of utilization review procedures and facilitate the efficiency and effectiveness of the review process.

"Guidelines for Concurrent Review and General Administrative Procedures" addresses several key issues that relate to utilization review conducted during a patient's course of treatment, including provider, payer and utilization review organizations in denial and appeal mechanisms, patient confidentiality and general contact procedures and time frames for reviews. These guidelines represent an addition to those released last summer on prior authorization programs and claims submission and review.

These five organizations will urge their members to utilize these "Guidelines" as the basis for discussion and implementation of utilization review programs. The groups hope to continue to work on additional issues of mutual concern regarding utilization review.

For additional information, contact Craig G. May, AMA, 312/464-5360.

NEW MEMBERS

Members of the Kentucky Medical Association and their respective county medical societies join in welcoming the following new members to these organizations.

Fayette

David B. Cassidy, MD — C
114 Stone Rd #A, Lexington 40503
1979, Tufts U

David T. Garrett, MD — OPH
120 N Eagle Cr, #211, Lexington 40508
1985, U of Kentucky
Mary C. Guiglia, MD — D
807 S Limestone, Lexington 40508
1984, U of Kentucky
Herbert Kaufer, MD — ORS
644 Lakeshore Dr, Lexington 40502
1959, U of Michigan
Christopher L. Montgomery, MD — AN
1316 Bordeaux Dr, Lexington 40504
1985, U of Kentucky
Timothy K. Neufeld, MD — NEP
2316 Woodfield Cir, Lexington 40515
1985, U of Kansas
Charles L. Papp, MD — ORS
217 Desha Rd, Lexington 40502
1984, U of California
Donna E. Roth, MD — D
1401 Harrodsburg Rd, #A-500, Lexington 40504
1986, State U of New York, Syracuse
Val M. Runge, MD — R
3904 Peppertree, Lexington 40513
1982, Stanford U, Palo Alto
Peter S. Tate, MD — S
2368 Nicholasville Rd, #302, Lexington 40503
1982, U of Kentucky
John M. Van Deren, III, MD — C
605 Summershade Cir, Lexington 40502
1983, Brown U, Providence
Susan H. Wermeling, MD — PS
4889 Wyndhurst, Lexington 40515
1983, U of Michigan

Floyd

Conrad M. Recio, MD — PD
Box 1270, Martin 41649
1951, U of the Philippines

Jefferson

Randall D. Jenkins, MD — PD
9003 Gilpin Pl, #8, Louisville 40222
1980, Wright State U
Barbara L. Kennedy, MD — P
724 Fairhill Dr, Louisville 40207
1973, Medical Col of Pennsylvania
James Anthony Wright, MD — FP
10216 Taylorsville Rd, Louisville 40299
1986, U of Kentucky

Marion

Frederick A. Dorroh, MD — S
496 W Main St, Lebanon 40003
1985, U of Kentucky

New In-Training

UK —
Lane C. Childs, MD — U
William K. Lawrence, MD — R
Deborah M. Martz, DO — FP
UL —
Victor James Shpilberg, MD — GP
Brenda I. Townes, MD — IM

DEATHS

Stanley T. Simmons, MD
Coral Gables, FL
1891-1990

Stanley T. Simmons, MD, a retired internist, died August 29, 1990. Dr Simmons was a 1924 graduate of the University of Louisville School of Medicine. He joined KMA in 1933 and was a life member.

Booker T. Holmes, MD
Frankfort
1905-1990

Booker T. Holmes, MD, a retired general practitioner, died September 5, 1990. A 1947 graduate of Meharry Medical College, Dr Holmes became active in KMA in 1965 and was a life member.

Charles B. Wathen, MD
Louisville
1913-1990

Charles B. Wathen, MD, a retired surgeon and occupational medicine physician, died September 17, 1990. Dr Wathen was a 1940 graduate of Washington University School of Medicine, joined KMA in 1947, and was a life member.

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

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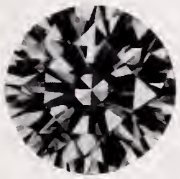

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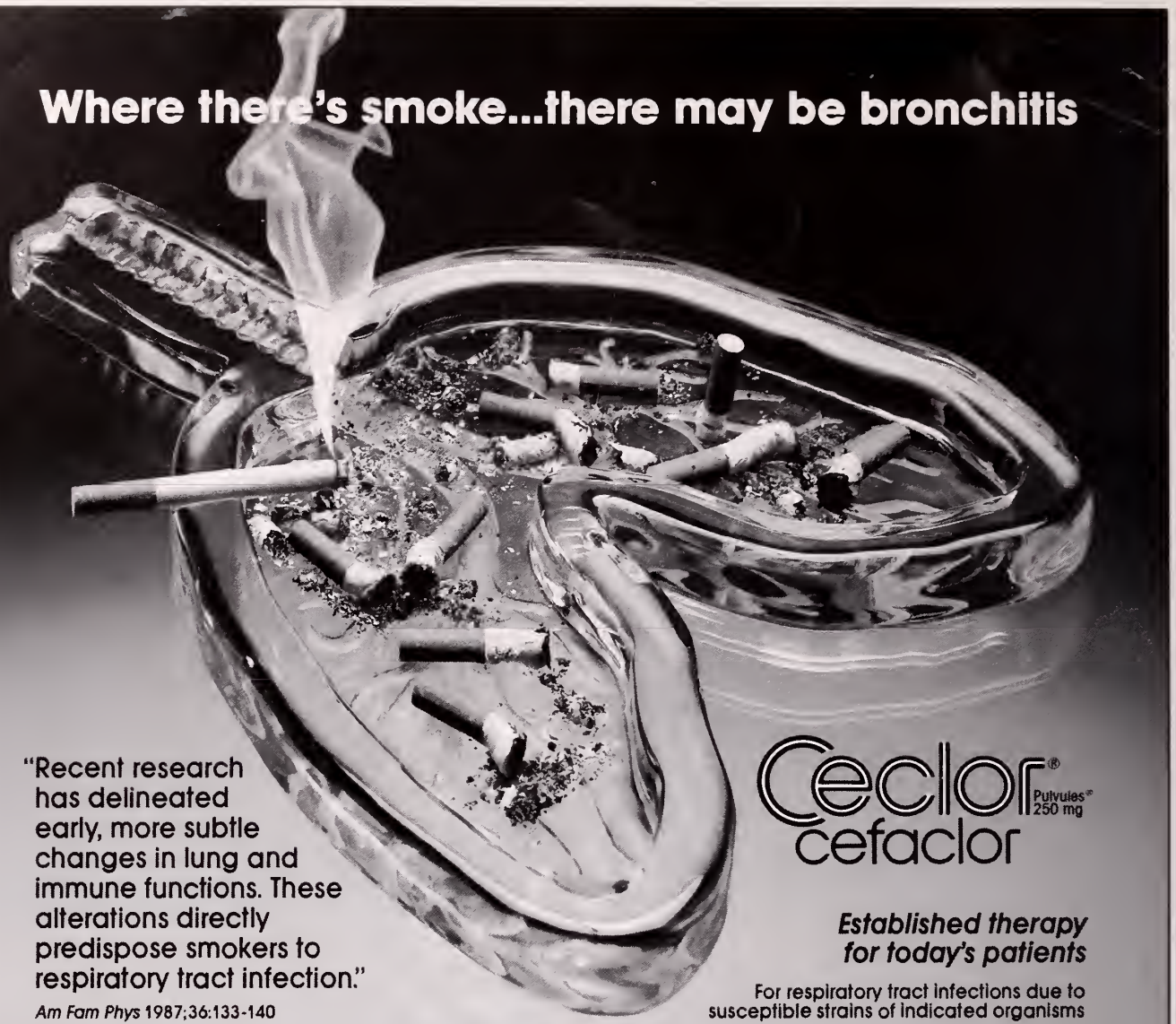

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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of non-susceptible organisms.
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• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
• Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
• Slight elevations in hepatic enzymes.
• Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
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DECEMBER 1990

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A Happy New Year

JOURNAL OF THE

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VOLUME 88, NUMBER 12 DECEMBER 1990

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Peace

The 1990-91 year began with a promise of a busy but relatively quiet Associational year, allowing us to build on activities and projects which serve to promote cohesiveness within the oganization. We promised you that we would concentrate on positives. Unfortunately, we were blindsided by a Supreme Court decision, got drawn into a political storm, and suddenly found ourselves party to the environmental crisis.

The Kentucky Supreme Court, with its incredible and increasing shift to plaintiff's point of view, held unconstitutional the statute of limitations which barred suits more than 5 years after any alleged negligence, regardless of whether the patient may have discovered an injury. Secondly, the definition of a physician's office has been drawn into the abortion controversy and may affect our future as we struggle to stay out of the eye of this political storm. Finally, the Governor's call for a Special Session to deal with solid waste disposal has generated discussions within the administrative and legislative arena regarding the handling and disposal of medical waste from physicians' offices.

While these issues gain our attention and require us to rearrange our priorities and meet them aggressively and resolutely, we need to pause at this special time of the year and be thankful for the abundance of goodness and prosperity that accrues to those of us so fortunate to be Americans.

While the drums of war beat in the Middle East and hundreds of thousands of our finest young women and men face an uncertain and agonizing future, family, friends, God and Country become foremost in our minds.

Our Country was built from the sacrifices and accomplishments of those who preceded us. It now becomes our task to choose the path, to carry the torch for those who follow. Almost 50 years ago a young German theologian, Dietrich Bonhoffer, confronted with choices, objected openly and often to the tyranny of Hitler and his Nazi holocaust. He was imprisoned and shortly before the Gestapo took him to the gallows he penned the following, which summarizes the challenges and choices we still face today.

> *For most people, not to plan for the future means to live irresponsibly, to live just for the moment while some few continue to dream of a better world. But we cannot take either of these courses. We are still left with only the narrow way, a way hardly to be found, of living every day as if it were our last. Thinking and acting for the sake of the coming generation, but taking each day as it comes without fear or anxiety — that is the spirit in which we are being forced to live in practice. It is not easy to be brave and hold out — but it is imperative. Tomorrow may be the day of judgment. If it is, I shall gladly give up working for a better world, but not before.*

Lucille and I, and the entire Nunnelley family, wish for each of you and your families and staffs a Happy Holiday Season and a New Year of Peace.

Preston P. Nunnelley, MD
KMA President

'Lucille and I, and the entire Nunnelley family, wish for each of you and your families and staffs a Happy Holiday Season and a New Year of Peace.'

Re-introduce The Oldest Advance In Medicines.

It's called talking. Right or wrong, many older people today feel that doctors just don't spend as much time talking with their patients as they used to. Things seem more rushed and hurried.

But talking, especially about medicines, is more important than ever before. Your older patients may be taking several different medicines and seeing more than one doctor. And many older people are treating themselves with over-the-counter drugs.

Unfortunately, an older person's response to medicines is less predictable than a younger person's. They can experience altered drug actions and adverse drug reactions.

So, if they don't tell you first, ask them what they're taking and if the medicines are causing any problems. Take a complete medications history including both prescription *and* non-prescription medicines.

Make it a point to tell them what they need to know — the medicine's name, how and when to take it, precautions, and possible side effects. Give them written or printed information they can take home, and encourage them to write down what you tell them.

Good, clear communication about medicines can increase compliance, prevent problems, and lead to better health.

So re-introduce the oldest advance in medicines. Make talking a crucial part of your practice. It isn't a thing of the past. It's the way to a healthier future.

Before they take it, talk about it.

National Council on
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ARMY RESERVE MEDICAL PROFILE NO.9

Dr. Holwick outside of hospital where she practices as a civilian traumatologist.

Dr. Holwick in operating room at Letterman Army Medical Center.

JANN L. HOLWICK, M.D.

General and Trauma Surgeon.
Captain, U.S. Army Reserve.

EDUCATION University of Southern California, B.S.; University of California School of Medicine.

RESIDENCY Harbor General Hospital—UCLA Medical Center.

HOSPITAL AFFILIATIONS St. Luke Hospital; Huntington Memorial Hospital, Pasadena, California; Traumatologist, Arcadia Methodist Hospital, Arcadia, California.

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"When you enter private practice, the only cases seen are usually those limited to your specialty. Serving as a physician in the Army Reserve offers me a departure from my daily routine. I can be involved in virtually anything I choose. If a certain case interests me, I can ask to be part of the surgical team. If I wish to spend time teaching students, I have that option, too.

"As a Reserve physician, I've had the opportunity to interact with different people, from various backgrounds, with assorted medical and social viewpoints. As a result, I've grown as a physician and as a person.

"I spent six months looking into the Army Reserve program before I joined, wanting to make sure that my skill and time would be put to good use. I've been a Reservist three years now, and I still find it extremely rewarding. I have the satisfaction of knowing that I'm serving my country."

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Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus Influenzae*, and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins.
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
• Discontinue Ceclor in the event of allergic reactions to it.
• Prolonged use may result in overgrowth of non-susceptible organisms.
• Positive direct Coombs' tests have been reported during treatment with cephalosporins.
• Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
• Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
• Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
• Hypersensitivity reactions have been reported in about 1.5% of patients and include morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients. Cases of **serum-sickness-like** reactions have been reported with the use of Ceclor. These are characterized by findings of erythema multiforme, rashes, and other skin manifestations accompanied by arthritis/arthralgia, with or without fever, and differ from classic serum sickness in that there is infrequently associated lymphadenopathy and proteinuria, no circulating immune complexes, and no evidence to date of sequelae of the reaction. While further investigation is ongoing, **serum-sickness-like** reactions appear to be due to hypersensitivity and more often occur during or following a second (or subsequent) course of therapy with Ceclor. Such reactions have been reported more frequently in children than in adults with an overall occurrence ranging from 1 in 200 (0.5%) in one focused trial to 2 in 8,346 (0.024%) in overall clinical trials (with an incidence in children in clinical trials of 0.055%) to 1 in 38,000 (0.003%) in spontaneous event reports. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy; occasionally these reactions have resulted in hospitalization, usually of short duration (median hospitalization = two to three days, based on postmarketing surveillance studies). In those requiring hospitalization, the symptoms have ranged from mild to severe at the time of admission with more of the severe reactions occurring in children. Antihistamines and glucocorticoids appear to enhance resolution of the signs and symptoms. No serious sequelae have been reported.
• Stevens-Johnson syndrome, toxic epidermal necrolysis, and anaphylaxis have been reported rarely. Anaphylaxis may be more common in patients with a history of penicillin allergy.
• Gastrointestinal (mostly diarrhea): 2.5%
• Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
• As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
• Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
• Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1% and, rarely, thrombocytopenia and reversible interstitial nephritis.

Abnormalities in laboratory results of uncertain etiology.
• Slight elevations in hepatic enzymes.
• Transient lymphocytosis, leukopenia, and, rarely, hemolytic anemia and reversible neutropenia.
• Rare reports of increased prothrombin time with or without clinical bleeding in patients receiving Ceclor and Coumadin concomitantly.
• Abnormal urinalysis; elevations in BUN or serum creatinine.
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• False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Friends depart, and memory takes them
To her caverns, pure and deep

— THOMAS HAYNES BAYLY

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List of deceased physicians available to the *Journal* as of August 1, 1990.

Glioblastoma Multiforme in Adults: Results of Treatment

Baby Jose, MD; Art Duncan, MD; Kristie Paris, MD; Robert D. Lindberg, MD; William J. Spanos, Jr, MD

From the Department of Radiation Oncology, Brown Cancer Center, University of Louisville School of Medicine, Louisville, KY 40292.

Reprint requests to Baby Jose, MD, Associate Professor, Department of Radiation Oncology, Brown Cancer Center, University of Louisville School of Medicine, Louisville, KY 40292.

One hundred and thirty adult patients with brain tumors were treated in the Department of Radiation Oncology, Brown Cancer Center, University of Louisville School of Medicine from 1973 to 1980. Forty-one patients (39%) were diagnosed with glioblastoma multiforme. Forty-two percent of the patients were in the age group of 51-60 years. There were 24 males and 27 females. Forty-seven percent of the patients had partial resection, 27% had total excision and 26% had biopsy only. The radiation dose ranged from 4400 to 6600 rad with a median dose of 5500 rad. The median survival was 8.5 months, (range 3 to 120 months), 38% of patients survived one year or more and 10% survived 2 years or more. A detailed review of the current policy of treatment and of the ongoing clinical trials is done in this paper.

Introduction

Primary malignant brain tumors occur at an annual rate of approximately 4.5 cases per 100,000 population. Forty-three percent of these cases are malignant gliomas which include glioblastoma multiforme, malignant astrocytoma, and anaplastic astrocytoma. These tumors are usually fatal with a poor median survival.[1] This report is the experience in the management of 51 patients with glioblastoma multiforme in the Department of Radiation Oncology, University of Louisville School of Medicine from 1973 to 1980.

Table 1. Age at Diagnosis.

Age	Number of Patients	Percent
< 40 years	7	14
41 — 50 years	7	14
51 — 60 years	22	42
62 — 70 years	9	18
> 70 years	6	12
TOTAL	51	100

Median Age — 62 years
Range: 20 years — 76 years

Methods and Materials

One-hundred and thirty adult patients were treated with a diagnosis of malignant brain tumor during the above period. Fifty-one patients (39%) were diagnosed with glioblastoma multiforme and the rest included anaplastic astrocytoma (30 patients), low grade astrocytoma (29 patients), oligodendroglioma (7 patients), and others (meningioma, pineal tumor, etc — 13 patients). Forty-two percent of the patients were in the age group of 51-60 years (Table 1). There were 24 males (47%) and 27 females (53%); about 4% were blacks.

The work-up included proper history, physical examination, blood studies, x-rays, CT scan and angiography in selected patients. The most common sites of involvement were parietal and temporal lobes (Table 2). Forty-seven percent of the patients had partial resection of the tumor (Table 3) and all patients had tissue confirmation in this series.

Irradiation was given using CO^{60} or 4 MV linear accelerator supervoltage equipment. The majority of the patients received whole brain irradiation of 4500 rad in 5 weeks followed by boost by reduced fields. Eighty-four percent of the patients received a tumor dose in the range of 5001-6000 rad in 5 to 6 weeks time, 5 days per week (Table 4). The dose rate was 160 rad to 170 rad/day in the earlier part of the study and the dose rate was increased to 180 rad/day later. Patients received steroids during the course of irradiation. All patients had some of the acute side effects of the treatment such as hair loss, skin changes, etc.

Results

Of the 51 patients, 11 patients could not be followed for a long term basis due to change of residence, inability to contact, etc. The median follow-up time of the 40 remaining patients is 9.5 months with a a range of 2 to 120 months. The median survival of the followed patients is 8.5 months, range (3 mos — 120 mos) (Table 5). The patients who had total resection had a median survival of 12 months compared to those who had partial resection (8 months) or biopsy only (6.5

months) (Table 6). This trend is similar to the current surgical approach of removing as much tumor as possible without causing significant neurological sequelae. Fifteen patients (38%) lived 1 year or more and four (10%) patients lived 2 or more years. No late complication such as necrosis of the brain was recorded in the charts.

Discussion and Current Trends

This retrospective review reveals our experience which is similar to the reported results in the literature.[2,3,4] The age, performance status and the extent of necrosis in the tumor are considered the most important prognostic factors.[3,5] Due to the poor results using conventional treatments, new treatment approaches are being used in glioblastoma multiforme.

The use of CT and MRI scans with improved contrast agents will better define the extent of the tumor, thus helping the neurosurgeon and radiation oncologist in the local treatment.[6] Patients in the younger age group with good performance status are eligible for treatment with carmustine (BCNU) and irradiation.[2] The irradiation dose has been increased to 6000 to 6500 rad in 6 to 6-½ weeks time by an involved field based on the CT and MRI findings. There are ongoing clinical trials with new cytotoxic drugs, radiosensitizers (misonidazole), hyperfractionation (treating two or three times a day with irradiation), heavy particle radiotherapy, hyperthermia, interstitial irradiation (brain implants), bone marrow transplantation and Fluosol (to increase the oxygen content) in an attempt to improve the local control and the survival.[7-11]

In recent years interstitial implantation has been done with Iodine-125 and Iridium-192.[8-10] The early reports of response in recurrent tumors treated with interstitial implantations is in the range of 60% to 70% with an improvement in survival for 8 to 10 months. Szikla et al[12] performed implants with removable Ir^{192} wires in patients with Grade III and Grade IV gliomas and achieved a 2 year survival of 55% and 5 year survival of 19%. The median survival for recurrent-glioblastoma multiforme (18 patients) was 52 weeks and for anaplastic astrocytomas was 153 weeks.[13] The

Table 2. Location of Primary Tumor

Site	Number of Patients	Percent
Parietal Lobe	18	35
Temporal Lobe	17	33
Frontal Lobe	12	24
Occipital Lobe	2	4
Not Recorded	2	4
TOTAL	51	100

Table 3. Type of Surgery

Type	Number of Patients	Percent
Partial Resection	24	47
Total Excision	14	27
Biopsy Only	13	26
TOTAL	51	100

Table 4. Radiation Dose (Tumor Dose)

Dose	Number of Patients	Percent
< 5000 rad	3	6
5001-6000 rad	43	84
6001-7000 rad	5	10
TOTAL	51	100

Range: 4400 — 6600 rad
Median Dose: 5500 rad
Dose Rate: Earlier part of study — 160 to 170 rad/day
Later part of study — 170 to 180 rad/day 5 days/wk

Table 5. Survival Results

Median Survival — 8.5 months
Range — 3 mos. — 120 mos.
Number of patients who survived 1 year or more — 15 (38%)
Number of patients who survived 2 years or more — 4 (10%)
Median follow-up — 9.5 months
Range — 2 – 120 months

Table 6. Survival Results Based on Type of Resection

Type of Resection	Median Survival (months)	Range (months)
Total resection (14)	12	4-120
Partial resection (24)	8	3-46
Biopsy only (13)	6.5	3-12

Northern California Oncology Group has reported a 3 year survival of 53% in patients with anaplastic astrocytomas and 55% in patients with glioblastoma multiforme, when brain implants are used as boost with external irradiation.[14, 15] Other clinical trials are being done to use interstitial implantation as boost to the primary tumor after completion of external irradiation. The acute and late side effects of these treatments are being studied.

Currently the patients with high grade gliomas are treated in our institution to a dose of 4500 rad in 5 weeks time (5 days/week) with a defined margin of 2-3 cm around the tumor, based on the CT or MRI findings. The volume is reduced by using custom-made blocks at 4500 rad and is boosted up to a dose of 6500 rad, without any break in between. We are also participating in a national trial using Fluosol with irradiation in high grade tumors. Interstitial implantation (open or stereotactic) is also used in recurrent tumors or as a boost after the external irradiation.

Summary

A retrospective study of 51 patients with glioblastoma multiforme, treated in the Department of Radiation Oncology, University of Louisville School of Medicine, from 1973-1980 is presented. The median survival was only 8.5 months with a 10% 2 year survival. Currently, the total irradiation dose has been increased to 6500 rad without a break. In addition, we add brain implants in appropriate patients and participate in national clinical trials.

ACKNOWLEDGMENT: The authors thank Mrs Barbara Leggett for preparing this manuscript.

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Violence in Medicine

Currently we are confronted with a new threat to our peace. Offices, factories, restaurants, stores, — no longer can we secure ourselves behind the protective walls of institutions that only a generation ago seemed immune to invasion. Domestic violence seemed to be a part of life for some families. Newspapers detailed mates and offspring, cousins and other relations, venting their rage on those close to them. Whether one or several members of a family circle were struck, somehow although outraged, we had come to accept that savagery as inherent in human genetics. Certainly not all of us have had to endure such happenings, but few of us can plead ignorance or not have someone — friend or relative — affected by such behavior.

'Our colleague settled into an office visit from which he was not to survive. Unprecipitated and probably unpredictable, a patient ended two lives with two cartridges and forever we are changed.'

Emergency room medicine graphically taught us that not all jungle warfare takes place in Africa, Asia, etc. Bloody bodies and screaming voices struck our conscience, almost as sharply as the blades of the perpetrators. For all the rage that took place outside the doors, once the border of the emergency room was crossed, most of the aggression dissipated. Sitting in the psychiatric room waiting for the referred patient to be brought through the door, not any of us could deny that fear of harm was not part of our transference. Incidents involving us were rare, and often punctuated by a particularly vile actor who somehow escaped the shackles of the police or disguised his purpose with a more quiet demeanor.

Workers in factories were likewise dealing with the demands of the job. Safety questions revolved around the machine at hand with its moving parts menacing the operators. Signs posted documented the dangers at hand, and **BEWARE** signaled the reader to be cautious. Certainly stores with sales people, offices with clericals, restaurants with servers had similar concerns. Each work place had its rules and regulations and obedience to these codes assured the workers of safety. Unpredictable fires and explosions, nature acting out with wind or water, ground shaking from earthquakes were somehow acceptable, even inevitable.

Within the decade things have changed. Maybe there are too many guns. Maybe there are too many bad or sick people with guns or knives or whatever can be used to destroy. Regardless of etiology, a crescendo of violence seems to be building. McDonalds was home to the burger and the shake, but in small town California it became a graveyard. School yards filled with frolic and laughter were silenced by the crackling of exploding bullets. Then our downtown daily became an inferno of death and injury when a dysphoric worker became a fatal invader. Neither walls, nor doors, nor steps could halt his path. No longer could people escape what in past years was somebody else's problem. Aggression was not the fodder of the workplace. Such activity should not and never did, till then, take place. Medical personnel stretched their experience to the limits, patching together the few parts of peoples' lives that could be mended. We felt the problem almost clinically, having the emergency training under our belts and the daily interactions with our patients for current medical education.

'White jackets and prescription pads are no security blanket. Violence has inserted itself into the medical milieu with thunder.'

Such ivory tower mentality came tumbling down with one senseless act. Our colleague settled into an office visit from which he was not to survive. Unprecipitated and probably unpredictable, a patient ended two lives with two cartridges and forever we are changed. Not on the front battlelines, not at war, now we are on the front line where an interaction with a patient may be no safer than a position on the manufacturing line. White jackets and prescription pads

'Now is the time for us to take the forefront . . . government must be selected that will literally "keep the peace," not just house the unpeaceful.'

are no security blanket. Violence has inserted itself into the medical milieu with thunder.

Now is the time for us to take the forefront. Studies of violent behavior, of drugs and their potential for changing mentation, diagnosis of human turmoil, and increased efforts at prevention are opportunities. Government must be selected that will literally "keep the peace," not just house the unpeaceful. Destructive things must be controlled and subject to regulation of their use. Death by knife, by explosion, by poison, by clouds of gas is still death against our will. Our moral backbone can support all these efforts to bring reason where insanity lurks. Physicians have intimate knowledge of human behavior from their practice and their exposure to daily troubles. Now that our own safety and well-being is not guaranteed, we too will go to our jobs with some fear of the unknown. Our ancestors in medicine were fearful of disease and of the elements, while in just the recent past most of these dangers for us were eliminated. No more and probably in some ways for the better. To the degree that we become more human, that we also should fear and worry, will we evolve into better healers and tenders to the sick.

Stephen Z. Smith, MD

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G = Have you ever felt bad or **guilty** about your drinking?

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ANNUAL MEETING

Clockwise from top left:

Preston P. Nunnelley, MD, Lexington, took the oath to become KMA's 140th President from Chairman William B. Monnig, MD.

President Nunnelley is pictured with President-Elect S. Randolph Scheen, MD, Louisville (R), and Secretary-Treasurer William P. VonderHaar, MD, Louisville.

Sharing a break in House action were (L to R) House Speaker Danny M. Clark, MD, Somerset, newly elected Vice President William B. Monnig, MD, Edgewood, and Vice Speaker C. Kenneth Peters, MD, Louisville.

President Nunnelley presented the Past President's plaque to Nelson B. Rue, MD, Bowling Green.

KMA President Nunnelley and his wife, Lucille, enjoyed a very exciting inauguration day.

AMA President C. John Tupper, MD, discussed a Medicare issue with Robert G. Cox, KMA Executive Vice President (L).

Awards Chairman S. Randolph Scheen, MD, had the pleasure of presenting KMA's highest honor, the Distinguished Service Award, to Wally O. Montgomery, MD, Paducah (R).

A capacity crowd attended the President's Luncheon.

1990

Inauguration

Preston P. Nunnelley, MD, a Lexington OB-GYN, was inaugurated 1990-91 President of KMA at the 140th Annual Meeting held in Louisville, September 24-27. Dr Nunnelley, a graduate of the University of Kentucky College of Medicine, has served KMA as President-Elect, 10th District Trustee for 5 years, and Vice Chairman of the Board of Trustees. He has also served on numerous committees including Legislative, Nominating, Kentucky Physicians' Care, State Legislative Activities, Executive, Scientific Program, Membership, and Ad Hoc Committee on Professional Liability Insurance.

Elections

S. Randolph Scheen, MD, a Louisville dermatologist, was elected

Top photo: 11th District Trustee William H. Mitchell, MD, Richmond, conversed with Dwight L. Blackburn, MD, Louisville. Bottom: President-Elect S. Randolph Scheen was escorted to the podium by Past Presidents Wally O. Montgomery, MD (L), and Bob M. DeWeese, MD (R).

to the office of President-Elect of KMA. A graduate of the University of Louisville and University of Minnesota medical schools, Dr Scheen has served on the KMA Board for 23 years. He was Secretary of KMA for 8 years before his election as Secretary-Treasurer in 1975. Committee memberships include Budget, Judicial Council, Ad Hoc Committee on Professional Liability Insurance, and Chairman of the Awards Committee. Dr Scheen will assume the office of President at the 1991 Annual Meeting.

William B. Monnig, MD, a urologist from Edgewood, was elected to the office of Vice President. Dr Monnig served KMA as Chairman of the Board of Trustees from 1988 to 1990, as 8th District Trustee from 1984 to 1990, and as Hospital Medical Staff Association State Chairman from 1984 to 1988. Committees include Medical Insurance and Prepayment Plans, Physician-Attorney Liaison, and Ad Hoc Committee on Professional Liability Insurance.

William P. VonderHaar, MD, a Louisville family practitioner, was elected Secretary-Treasurer, and three new Trustees were elected: Joseph E. Kutz, MD, Louisville, 5th District; Mark F. Pelstring, MD, Covington, 8th District; and Paul R. Smith, MD, London, 15th District. Reelected to 3-year terms were Jerry W. Martin, MD, Bowling Green, 6th District Trustee, and William H. Mitchell, MD, Richmond, 11th District Trustee.

In other House elections, Robert

Top photo: AMA Senior Delegate Donald C. Barton, MD, Corbin (L), and Paul R. Smith, MD, London, studied resolutions presented for action. Center: Russell L. Travis, MD, Lexington, addressed the delegation concerning the Physicians' Care Program. Bottom: Loman C. Trover, MD, Madisonville, received KMA's Educational Achievement Award.

R. Goodin, MD, Louisville, was elected Delegate to the AMA, and Wally O. Montgomery, MD, Paducah, was reelected as AMA Delegate. Bob M. DeWeese, MD, Louisville, was elected Alternate Delegate to the AMA, and Ardis D. Hoven, MD, Lexington, was reelected AMA Alternate Delegate.

Board of Trustees elections included Cecil D. Martin, MD, Carrollton, as Chairman of the KMA Board of Trustees, and Lucian Y. Moreman, II, MD, Elizabethtown, Vice Chairman of the Board. John W. McClellan, Jr, MD, Henderson, and William H. Mitchell, MD, Richmond, joined the KMA Executive Committee.

Five physicians were elected by the House of Delegates to serve on the 1990 Nominating Committee. Members elected were:

Hank Bell, Jr, MD,
Elkton, Chairman
John D. Ammon, MD
Florence
Ralph D. Caldroney, MD
Lexington
Marion A. Douglass, MD
Magnolia
Audrey Spencer, MD
Maysville

President's Luncheon

A capacity crowd at the President's Luncheon honored outgoing President Nelson B. Rue, MD, and witnessed the installation of Preston P. Nunnelley, MD, as the 140th President of KMA.

In his inaugural address, Dr Nunnelley emphasized his theme for the year, "Pride in Medicine." Comments of note included, "I do believe that we can do a better job of documenting and publicizing our achievements without being defensive and without being apologetic. The health care industry has every right to demand respect for our contributions to health care, for our productivity, and our standards. . . . We must reignite the fire that existed within us when we chose to become physicians, for the task ahead will not be easy. . . . Face-to-face contact with three-fourths of the American population, organized and utilized properly, can go a long way in changing our image. . . . No other profession offers so much in terms of pure joy and sense of accomplishment."

DSA Award

The Association's most prestigious honor, the Distinguished Service Award, was presented to Wally O. Montgomery, MD, a Paducah general surgeon. Dr Montgomery was honored at the President's Luncheon for his long and distinguished service to the Association. He has served on the KMA Board of Trustees since 1976 as Trustee, Vice President, and in 1985-86 as President of KMA. In addition, he has served as KMA Alternate Delegate to the AMA and currently serves as Delegate to AMA.

Dr Montgomery was also recognized for his exemplary service in the political arena where he has excelled and perhaps made his finest contributions to medicine. He has served KMA for many years as a member of both the National and State Legislative Committees, served 6 years as a member of the KEMPAC Board of Directors including two terms as Chairman of the Board, and has been extremely involved in local, state, and national politics, supporting candidates who share his philosophy and have an interest in the delivery of health care. As Chairman of the KMA Committee on State Legislative Activities, Dr Montgomery has made numerous trips from Paducah to Frankfort during the Legislature. Under his leadership, KMA has expanded its legislative effort and maintained year-round activities monitoring various interim committees and other governmental functions.

With the support of his wife,

Top photo: AKMA Past President Esther Jansing, Owensboro, presented AMA-ERF checks to UofL and UofK. Center: KMA Past Presidents Hoyt C. Gardner, MD (R), and Charles C. Smith, Jr, MD (L), both of Louisville, are pictured with KMA Executive Vice President Robert G. Cox. Dr Gardner is also a Past President of the American Medical Association. Bottom L to R: Madisonville physicians Charles R. Dodds, James M. Bowles, W. Ford Threlkeld, and Wallace R. Alexander are seated with 2nd District Trustee John W. McClellan, MD, Henderson.

Gerry Montgomery, who is the honorable Mayor of Paducah and a Past President of the Auxiliary to KMA, Dr Montgomery is also extensively involved in his local community and church, as well as serving as a Colonel in the US Army Reserve.

In his presentation of the award to Dr Montgomery, S. Randolph Scheen, MD, Chairman of the Awards Committee, concluded with this observation, "Our honoree has imparted to his profession, his community, and to his family and friends the only truly important gifts any of us really have — knowledge . . . experience . . . devotion . . . and love. This he has done and done well."

Educational Achievement Award

The recipient of the KMA Educational Achievement Award for 1990 was Loman C. Trover, MD, of Madisonville. A respected physician, teacher, and community leader, Dr Trover orchestrated the development of Trover Clinic, a regional medical center in Madisonville which has received national recognition and provided much needed service for the rural western region of the Commonwealth.

Dr Trover also achieved distinction by playing a significant role in establishing the Madisonville Community College and the Vocational Region II Health Occupations School, as well as his efforts to diversify the economy by attracting the first major non-coal related industry to the region.

President Nelson B. Rue, MD, in making the presentation described Dr Trover as a physician who "exemplifies those special characteristics which have contributed to excellence in meeting the needs of his patients, his community, and the countless number of residents and students who have trained under his guidance."

Auxiliary AMA-ERF

During the first meeting of the House of Delegates, Esther Jansing, AKMA Past President, presented AMA-ERF checks to the two medical schools on behalf of the Auxiliary. Since 1950, the AMA-ERF has continually been supportive of quality

Top photo: AMPAC Chairman Randolph D. Smoak, MD, addressed the KEMPAC gathering. Center: President Nelson B. Rue, MD, presented a framed print to be displayed in the Headquarter's Building. President-Elect Nunnelley looked on. Bottom L to R: Drs Ray A. Cave, Leitchfield; 6th District Trustee Jerry W. Martin, Bowling Green; 9th District Trustee Kelly G. Moss, Maysville; Harold D. Haller, Louisville; and AMA Delegate Kenneth P. Crawford, Louisville.

medical education, with contributions now exceeding $2 million annually. The extraordinary fund-raising efforts of the AMA Auxiliary and the generosity of contributing medical families and private enterprise continue to secure AMA-ERF as a viable support for medical education. In Kentucky, AMA-ERF funds are given proportionally to the two medical schools as designated by the donors. Dr Donald R. Kmetz, Dean of the University of Louisville School of Medicine, accepted a check from Mrs Jansing for $27,378.73, and Dr Emery A. Wilson, Dean of the University of Kentucky College of Medicine, accepted a check for $18,514.23.

Fifty-Year Members

Fifty-year members were recognized during the President's Luncheon. They are those physicians who have been practicing medicine for 50 years or more. Those achieving that status this year are: Drs William E. Becknell, John P. Bell, Thomas E. Booth, Ralph L. Cash, Jr, Norvin L. Casper, Allen L. Cornish, Melvin L. Dean, Wynant Dean, Robert W. Dockery, James B. Douglas, Charles H. Duncan, Robert S. Dyer, James A. Freeman, Henry S. Harris, Anne H. Hopwood, James M. Huey, Robert C. Long, Loran P. Moore, Franklin P. Moosnick, Charles W. Morris, William J. Oldham, Harry M. Roach, George H. Rodman, Milo H. Schosser, Edwin P. Scott, George A. Sehlinger, Ansel V. Simon, Alec Spencer, Walter H. Stepchuck, Edward J. Stratman, John W. Turner, A. Samuel Warren, Charles B. Wathen.

In Memoriam

During the first House of Delegates meeting, Dr Randolph Scheen requested that the audience stand for a moment of silence in memory of those physician members who had died in the last year. A list of the deceased appears on page 649 of this *Journal*.

KMA-MSS and RPS

The KMA Medical Student Section held its third annual meeting on September 27 during the KMA meeting. The highlight of the program was a panel discussion entitled "Accelerated Training Program." Panelists were Alan K. David, MD, Chairman, UK Family Practice

Top L to R: Members of the Northern Kentucky delegation included Drs Fred A. Stine, Highland Heights, John D. Ammon, Florence, Charles F. Allnut, Covington, and Gordon W. Air, Crestview Hills. Center: Drs Robert L. McQuady, Larry P. Griffin, and Larry J. Wilson, all of Louisville, relaxed during the break.

Chairman David B. Stevens, MD, Lexington, presided over the KEMPAC meeting. In the KEMPAC booth was Vicki Thorpe who recently joined the KMA staff as Executive Secretary/KEMPAC.

Department; Scott Black, MD, UK Program Participant; H. David Wilson, MD, UK Pediatrics Professor; and Pat Dinning, a 4th year UK medical student.

For the first time, the KMA Resident Physicians Section held its annual meeting during the Association's meeting. Belle Kulick, AMA-RPS Policy Analyst from Chicago, addressed the group and gave a very informative presentation on "Student Loan Issues — Deductibility/ Deferment."

KEMPAC

The 28th KEMPAC Seminar Banquet was held during this year's Annual Meeting on Monday, September 24, at the Hyatt Regency Hotel, Louisville. A large audience of physicians, spouses, Kentucky State Representatives, Senators, and their staff were addressed by senatorial candidates Harvey I. Sloane, MD, and Senator Mitch McConnell — Dr Sloane in person and Senator McConnell by speaker-phone. Randolph D. Smoak, MD, AMPAC Chairman from Washington, DC, brought greetings from the national office. David B. Stevens, MD, Lexington, KEMPAC Chairman, presided at the meeting. Dr Stevens introduced Ms Vicki Thorpe who recently joined the KMA staff as Executive Secretary/KEMPAC.

House Action Summary

The 1990 KMA House of Delegates adjourned on September 26, 1990, having adopted the following recommendations included in over 40 Reports and 30 Resolutions.

- Recognized Pfizer/Roerig Laboratories officers and staff for making its entire product line available to Kentucky Physicians Care patients.
- Directed that AMA Senior Delegate obtain information regarding salaries/ benefits of AMA top echelon employees and make it available to

KMA members upon request.
• Expressed appreciation to Joe A. and Cecil Dulin Wallace for bequeathing Ephraim McDowell's summer home to the Ephraim McDowell Cambus-Kenneth Foundation.
• Honored the late John L. (Jack) Trevey, MD, for his contributions to the profession.
• Paid tribute to the late Ryan White for his efforts to assure every individual appropriate medical care regardless of malady.
• Reaffirmed KMA's commitment to its educational responsibility and encouraged all hospitals to support and participate in accredited CME activities.
• Endorsed and supported Radon Action Week and urged members to inform patients about health risks associated with radon and preventive steps available to measure and reduce excessive levels of radon.
• Directed that the KMA assist in professional and public education on the use of laser treatment of humans and urged the Board of Medical Licensure to monitor the use of laser in the practice of medicine.
• Directed a study of the establishment of a centralized database for all prescribed drugs or medications for easy access by physicians and pharmacists.
• Directed the printing of the model living will and health care surrogate documents along with appropriate informational materials and distribution at cost. Also urged physicians to have documents available for patients.
• Supported the encouragement and active solicitation of physicians to run for public office and to seek policy-setting positions with third party payors and insurors.
• Reaffirmed and re-endorsed the retention of Certificate of Need, maintained physician office exemption, and supported repeal of exemption from CON provided to Jefferson County hospitals during the

Top: Many instructive topics were covered during the scientific sessions where Kentucky physicians earned CME credits. Center: KMA Membership Coordinator Diane Maxey was available to answer questions in the very attractive membership booth.

For the first time in 12 years, retired House Speaker Peter C. Campbell, MD, Louisville (L), studied the resolutions from the opposite side of the table. David George, MD, Lexington, thoughtfully considered the volume of material.

Addressing the medical students were L to R: Dr Scott Black, Dr H. David Wilson, 4th year medical student Pat Dinning, and Dr Alan K. David.

Top student leaders for KMA and AMA presided at the meeting. Pictured are Baretta Casey (L), KMA-MSS President, and Judy Linger, Chairperson AMA-MSS, both of U of K.

This was the 3rd annual meeting for the Medical Student Section.

1990 Kentucky General Assembly.

- Opposed payment differentials to hospitals and physicians based on location, and continuation of a leadership role to remedy past injustices of payment levels and reflect the need not to diminish present reimbursement schedules.
- Urged Sentinel Medical Review Organization to hold meetings with local physicians to resolve concerns.
- Called for the resignation of HHS Inspector General Richard Kusserow and urged Kentucky's congressional delegation to persuade President Bush to seek Kusserow's resignation.
- Directed a study and recommendation of ways to encourage education of prenatal patients in the benefits of breast feeding.
- Directed that reimbursement policies should not discriminate against any class or specialty of physician, urged CHR to examine Medicaid reimbursement policies to reflect reimbursement levels proportionate to charges and levels of skill and training, regardless of physician location or specialty.
- Urged standardization of Medicare Supplement policies, including HMOs, consistent with model regulations.
- Urged county and city governments to develop local seat belt laws.
- Supported a drive for 100% KEMPAC/AMPAC membership in 1991.
- Called for a state legislative study and regulations of unsafe operations of water jet skis, boats, and alcohol use in water sports.
- Endorsed and encouraged Congress to enact HR 467 (Brady Bill) and called upon Kentucky's congressional delegation to support the legislation.
- Adopted an insurance bill of rights for patients to be made available to physicians and insurance companies.
- Recommended continuation of the Kentucky Physicians Care program.
- Directed a study of the issue of corporal punishment in schools.
- Opposed mandatory insurance coverage and supported the concept

The 1990 House of Delegates recognized Pfizer/Roerig Laboratories' officers and staff for making its entire product line available to Kentucky Physicians Care patients. Their sales representatives were on hand throughout the 3-day event to speak with attendees and to answer questions.

that health insurance benefits and coverages should be based on the group or individual's health insurance needs in accordance with ability to pay.

• Previous opposition to preadmission certificate changed to no position.

• Endorsed AMA's "Health Access America" proposal.

• Adopted changes in life membership and directed study of retired physicians who have reached age 65 with more than 25 years membership.

Attendance

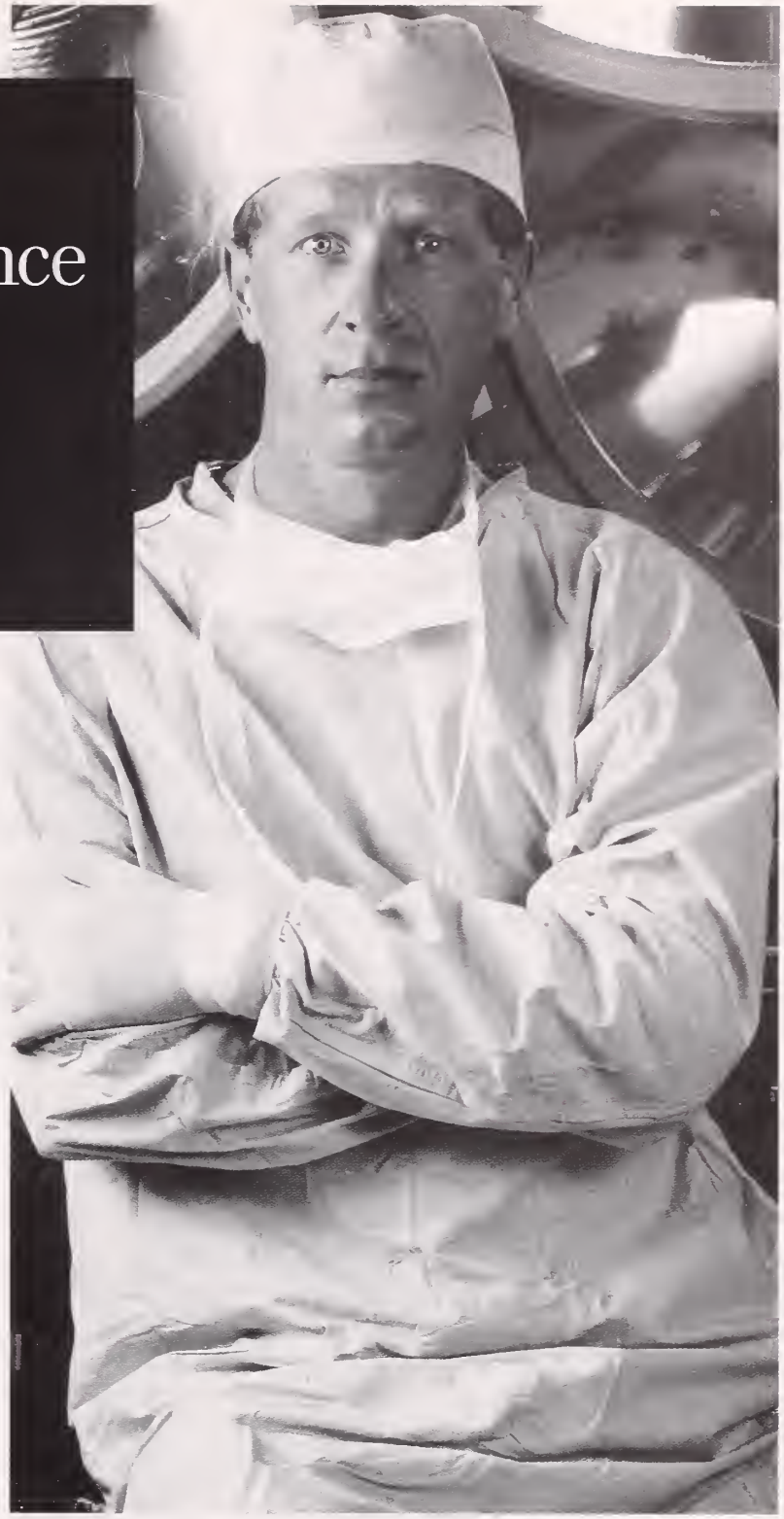
The Annual Meeting continued its record pace with a total registration of 2565, surpassing last year's attendance by almost 400. Physicians numbered 1158 and medical students 285, resulting in a very successful 140th KMA Annual Meeting at the Hyatt Regency Hotel/Commonwealth Convention Center in downtown Louisville.

The 1991 Annual Meeting will be held in Lexington. The Board of Trustees has selected the very accommodating and spacious Hyatt Regency Hotel as the facility to house the meeting. Over 22 specialty groups and an estimated 2300 registrants are expected to attend.

Mark your calendars to attend the 1991 Annual Meeting to be held September 29-October 3. *kma*

The spacious, convenient, and comfortable exhibit hall featured over 150 technical, scientific, and health exhibits.

"I switched to occurrence coverage without paying for a tail."



The Claims Made Trap. If you're caught in it, there's no easy way out. The only way to switch to occurrence, the coverage preferred by most doctors, has been to pay an expensive tail premium. Until now.

Medical Protective, the company that invented professional liability insurance 90 years ago, has a solution. Convertible Claims Made. Now you can get back to occurrence without buying a tail.

And when you choose Convertible Claims Made with Medical Protective, you not only get back on the road to occurrence, you get coverage with one of the most trusted and highly regarded professional liability carriers in America today. For the past 90 years, defending and insuring physicians, surgeons and dentists has been our only business. No one is more experienced or more committed. And our continuous A+ (Superior) rating from the A.M. Best Co. gives you the financial stability and strength that you need and expect from your professional liability carrier.

So, if you would like to escape the Claims Made Trap, look no further. Call us today and we'll show you how Convertible Claims Made makes it easy to step up to occurrence and Medical Protective.

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Serving Kentucky Physicians Since 1922.

Charles E. Foree, Jackquelyn A. McClain, Suite 102, 152 East Reynolds Road, Lexington, KY 40502, (606) 272-9124
Donald G. Greeno, Gary Duechle, Suite 152, Triad North Building, 10401 Linn Station Road, Louisville, KY 40223, (502) 425-6668
1-800-633-2578

Choosing a Health Plan

One of the problems with health insurance that physicians continually hear about from their patients is that patients aren't sure what types of coverages they should buy and many times find out after they have purchased a plan that it contains a number of exclusions or benefit limitations.

The Kentucky Medical Association has developed the following guide which we hope will aid individuals in their decision making process regarding health insurance.

Please feel free to remove this page and reproduce it as you feel appropriate. We hope you will find this information useful.

What is your specialty?

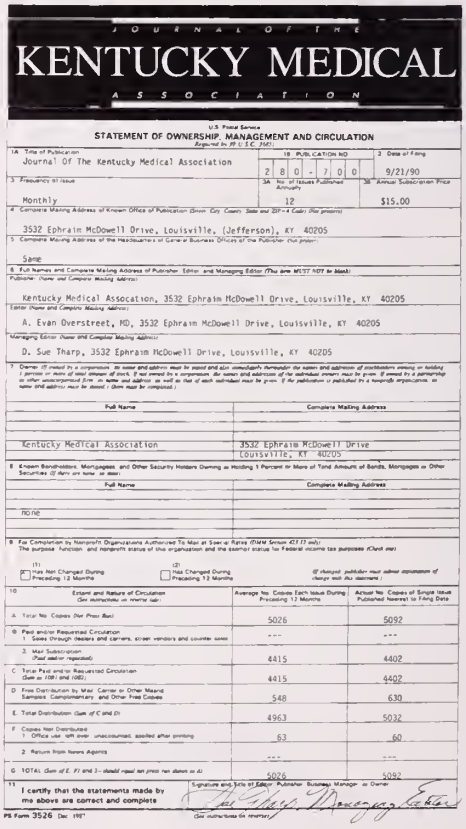
Doctor of Medicine (MD)
Doctor of Osteopathy (DO)

Whatever your medical specialty, you can count on the **Kentucky Air Guard** to put your skills to work in a way that will enrich your life and career.

To find out about:

Benefits
Eligibility
Participation requirements
Military grade
Military pay
Training
Assignments
Retirement

Contact: **SMSgt. Todd Beasley,**
Kentucky Air National Guard
(502) 364-9424 (call collect)



JOURNAL OF THE
KENTUCKY MEDICAL
ASSOCIATION

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☐ (2) Has Changed During Preceding 12 Months
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B. Paid and/or Requested Circulation 1. Sales Through Dealers and carriers, street vendors and counter sales	---	---
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11. I certify that the statements made by me above are correct and complete
Signature and Title of Editor, Publisher, Business Manager, or Owner
(See instructions on reverse)
PS Form 3526 Dec. 1987

What You Should Ask About Your Health Insurance

- May I choose my physician?
- Is my current physician a member of the plan?
- Will my prescription be paid?
- Are x-rays covered by the plan?
- Are office visits covered? Shots (injections)?
- Can I freely choose to see a specialist or must I be referred by my primary physician?
- Does my primary physician control access to specialty consultation?
- May I choose my hospital?
- Will lab tests be paid?
- Will specialists' services be covered?
- Must I have certain surgical procedures done as an outpatient?
- Will I be screened by medical personnel other than a physician before I see my doctor?
- Do I have easy access to a physician on week nights and weekends?
- Will my health care plan cover me for cost of medical treatment at out-of-town facilities when I travel?
- Will dependents be covered if they reside out-of-state?
- Can I get medical advice from a physician over the telephone during nonoffice hours?
- Am I limited to a certain number of routine care appointments?
- Must I schedule my appointments for routine care far in advance?
- Are any illnesses excluded from the coverage?
- May I request a "second opinion" from an outside physician? If so, will I have to pay for it?
- Will I have to pay a deductible or partial payment?
- When and how often are premium rates subject to change?
- Can I be let go from the plan without advance warning or if I use it too much?
- Do I have to fill out claim forms or will my doctor/hospital do that?
- May I use local physicians and hospitals or must I use those approved by the plan, even if I have to go to another community?
- Is my physician required to obtain permission from the plan before services are rendered?
- Will I be covered for urgent care if it is not rendered in a hospital associated with my health care plan?
- What happens if my physician ceases to be a participant in the plan while I am under his/her care?

Basic Health Care Plans

Fee-for-service is the traditional manner of receiving and paying for medical care. **You** choose your physician, hospital, and any other medical care you need. You are charged for the care you receive. Often, your care is paid for through a health insurance company whose premiums may be paid by employers. You may pay a deductible (an amount you must pay before your insurance company begins paying for your health care), or a co-payment (you pay a portion of the bill and the insurance company pays the balance).

Health Maintenance Organization (HMO)

An HMO is an organization that provides health care to a group of persons for a pre-determined price. An HMO offers broad coverage at a fixed price. The prepaid fee stays the same for a given period of time, usually one year regardless of the amount of health care used. That fee may be paid by you or, in full or in part by an employer, government or some other sponsor. In some HMOs, services are offered only at specific locations by groups of physicians and other health care personnel. You are required to use the HMO facility and staff to receive medical care.

Independent Practice Association (IPA)

An IPA is a type of HMO. Physicians practice in their office and care for both IPA subscribers and other patients. IPAs are formed by physicians who enter into agreements, usually with an employer group or insurance company, to provide medical services to that group's employees. Since the IPA is an HMO, the patient still must choose a particular group of physicians and a specific medical facility from which to receive medical services.

Preferred Provider Organization (PPO)

A PPO is a group of health care providers who agree to provide services to a specific group of patients (usually employment based groups) at an agreed upon rate.

A Word of Caution

Keep in mind that there are many different types of HMOs, PPOs, IPAs, and other insurance plans being offered today. Each of them has specific restrictions as to the type of care you receive, where you receive it and from whom. Before joining any plan, or before changing your current medical plan, learn as much as possible about the options being offered to you. Ask for written information which outlines the pluses and minuses of each option and read it carefully. Before you make a final decision, discuss the options with your personal physician to make certain that you will be able to receive the care you need under the option you choose.

Finally...

You should realize that many employers choose a plan for their employees. You may not have a choice. However, the information and questions contained in this article will, at the very least, make you more aware of your current health care plan.

Your physician is the best person to help you understand what's happening in medicine today. If you have questions about any subject mentioned here, we encourage you to ask your physician.

"Okay, so I know I need iron. Where do I get it?"

Faced with a Recommended Daily Dietary Allowance of 15 mg, the question is a good one for women aged 19-50. Iron is one of the nutrients most often lacking in the American diet. Low intakes of iron over prolonged time can lead to iron deficiency anemia.

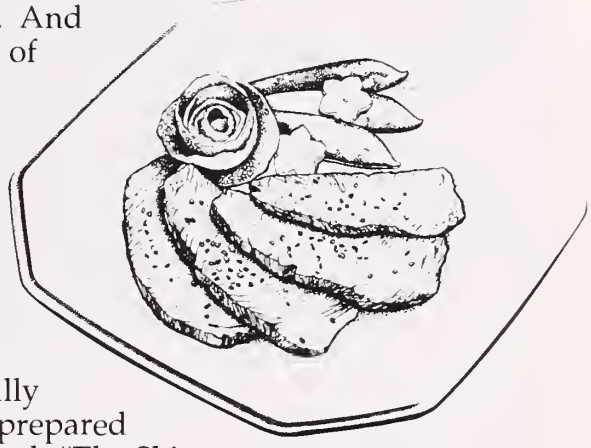
In the 1986 USDA Continuing Survey of Food Intakes by Individuals[1], women of child-bearing years reported a mean intake of 1588 calories a day. Since the American diet averages about 6-7 mg iron per 1000 calories, it's not surprising that the same survey found that most of these women are getting about 60 percent of their RDA for iron.

Yet consider, one three-ounce serving of lean sirloin contains 2.8 mg of iron, about forty to sixty percent of which is heme iron, the most bioavailable form. In addition, the presence of beef or other meats in a meal increase the bioavailability of nonheme iron from foods such as vegetables and grains.

Importantly, lean beef can also meet fat and cholesterol guidelines of most leading heart and health authorities. The how-to's are good advice for almost anyone.

Start with "The Skinniest Six" shown below. None is more than 180 calories per three-ounce cooked, trimmed serving. All are easy to specify at the meat counter.

These six cuts also simplify portion control. Four ounces uncooked equals about three ounces cooked. Grilling, broiling and roasting add no extra fat in cooking. And the taste of beef makes it easy to dispense with fat-laden sauces.

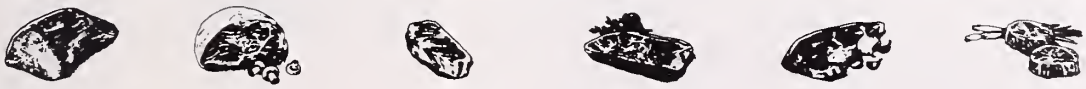


Carefully chosen, prepared and served, "The Skinniest Six" provide an impressive list of essential nutrients for under 180 calories per three-ounce serving.

And as part of a specific plan to increase dietary iron, in a balanced diet, beef can be one of the best-tasting recommendations you'll ever make.

BEEF

*"The Skinniest Six"**



Eye of Round	Round Tip	Top Loin	Top Round	Sirloin	Tenderloin
1.65 mg iron	2.50 mg iron	2.10 mg iron	2.45 mg iron	2.85 mg iron	3.05 mg iron
155 calories	162 calories	172 calories	162 calories	177 calories	174 calories
5.5 g total fat	6.4 g total fat	7.6 g total fat	5.3 g total fat	7.4 g total fat	7.9 g total fat
(2.1 g saturated fat)	(2.3 g saturated fat)	(3.0 g saturated fat)	(1.8 g saturated fat)	(3.0 g saturated fat)	(3.1 g saturated fat)
59 mg cholesterol	69 mg cholesterol	65 mg cholesterol	72 mg cholesterol	76 mg cholesterol	72 mg cholesterol

Uncooked whole cuts are shown for purpose of identification.

Composite of cooked retail cuts of beef*

Protein	25.9 g
Iron	2.7 mg
Zinc	6.0 mg
Vitamin B-12	2.28 mcg
Thiamin	.08 mg
Niacin	3.6 mg
Sodium	55 mg
Total Fat	8.7 mg
(Saturated Fat)	(3.4 g)
Cholesterol	76 mg
Calories	189

[1] United States Department of Agriculture, "Nationwide Food Consumption Survey, Continuing Survey of Food Intakes by Individuals (NFCS, CSFII) "Report No. 86-1.

* Nutrients in 3 oz. trimmed and cooked: USDA Handbook 8-13, Rev 1986

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AIR FORCE

Letters From Annual Meeting Guests

October 1, 1990

Nelson B. Rue, Jr, MD, President
Kentucky Medical Association

Dear Nelson:

This is just a brief note to thank you and the members of your association for your delightful hospitality and friendship on my visit with you last week. Mary and I are delighted with the beautiful stoneware mug filled with Kentucky bourbon candy and the handsome book about Kentucky, which we have looked at with pleasure and will plan on reviewing more thoroughly in the near future.

It was a great pleasure to have an opportunity to be with you.

Sincerely yours,
C. J. Tupper, MD
President, AMA

October 1, 1990

Nelson B. Rue, Jr, MD
President
Kentucky Medical Association

Dear Dr. Rue:

This is just a short note to thank you and the staff of the KMA for its invitation and hospitality on my recent trip to Louisville. It was an interesting and enjoyable visit. Thanks again for having me.

Sincerely,
Vincent A. DeLeo, MD
Assistant Professor of Dermatology
College of Physicians & Surgeons
Columbia University

September 30, 1990

Preston P. Nunnelley, MD
Kentucky Medical Association

Dear Preston:

Shirley joins me in thanking you and the staff of KMA for your gracious hospitality during our visit to the KMA meeting. It was a well-run meeting with ample discussion. The night at the Derby Museum was dramatic and happy.

I look forward to working with you.

Sincerely,
Jack Devaney, MD
President
Ohio State Medical Association

Was Your Delegate Present?
ROLL CALL
1990 House of Delegates
KMA Annual Meeting

OFFICERS

		First Meeting	Second Meeting
Speaker	Donny M. Clark	Present	Present
Vice Speaker	C. Kenneth Peters	Present	Present
President	Nelson B. Rue	Present	Present
President-Elect	Preston P. Nunnelley	Present	Present
Vice-President	John D. Noonan	Present	Present
Secretary-Treasurer	S. Randolph Scheen	Present	Present
Delegate to the AMA	Donald C. Barton	Present	Present
Delegate to the AMA	Harold L. Bushey	Present	Present
Delegate to the AMA	Kenneth P. Crowford	Present	Present
Delegate to the AMA	Wally O. Montgomery	Present	Present
Alternate Delegate to the AMA	Larry C. Franks	Present	Present
Alternate Delegate to the AMA	Robert R. Goodin	Present	.....
Alternate Delegate to the AMA	Ardis D. Hoven	.....	Present
Alternate Delegate to the AMA	Donald J. Swikert	....	Present

TRUSTEES

District			
First	Robert P. Meriwether		
Second	John W. McClellon, Jr	Present	....
Third	William L. Miller	Present	Present
Fourth	Lucion Y. Moremon, II	.....	.....
Fifth	Larry P. Griffin	Present	Present
Sixth	Jerry W. Martin	Present	Present
Seventh	Cecil D. Martin	Present	Present
Eighth	William B. Mannig	Present	Present
Ninth	Kelly G. Moss	Present	Present
Tenth	Russell L. Travis	.....	Present
Eleventh	William H. Mitchell	.....	Present
Twelfth	David C. Liebschutz	Present	Present
Thirteenth	Charles T. Watson	Present	Present
Fourteenth	James R. Pigg	Present	Present
Fifteenth	Emmanuel H. Roder	Present	Present

ALTERNATE TRUSTEES

District			
First	Don M. Miller	Present	Present
Second	Christopher R. McCoy	.....	.....
Third	Charles R. Dodds	Present	Present
Fourth	Salem M. George	.....	Present
Fifth	Gordon T. McMurry	Present	Present
Sixth	Jerry L. Gibbs	.....	.....
Seventh	William P. McElwain	.....	.....
Eighth	Mark F. Pelstring	Present	Present
Ninth	Don R. Stephens	Present	Present
Tenth	Thomas K. Slobaugh	Present	Present
Eleventh	John M. Johnstone	.....	.....
Twelfth	Scott B. Scutchfield	Present	Present
Thirteenth	Bruce M. Stapleton	Present	Present
Fourteenth	Nicholas R. Jurich	.....	.....
Fifteenth	Paul R. Smith	.....	.....

PAST PRESIDENTS

Past President	Bob M. DeWeese	....	Present
Past President	Donald C. Barton	Present	Present
Past President	Richard F. Hench	.....	.....
Past President	Wally O. Montgomery	Present	Present
Past President	Charles C. Smith, Jr	.....	Present

DELEGATES
FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD			
CALLOWAY	R. Gary Marquardt	Present	Present
CARLISLE			
FULTON			
GRAVES	Robert D. Fields	.....	.....
	Charles D. LeNeave	Present	.....
HICKMAN	Bruce C. Smith	.....	.....
LIVINGSTON	Stephen Burkhart	.....	.....
MCCRACKEN	Harry W. Carloss	Present	Present
	Gerald E. Kakoscik	Present	Present
	Marshall M. Poor, Jr	.....	.....
	Peter Allan Ward	Present	Present
MARSHALL	H. W. Ford	.....	.....

SECOND DISTRICT

DAVIESS	Bill J. Bryant	.....	Present
	Royce E. Dawson	.....	Present
	John T. Houston	.....	Present
	John D. Jefferies	Present	Present
	Ronald M. Johnson	Present	Present
	Linda Mumford	.....	Present
HANCOCK			
HENDERSON	Frank K. Sewell, Jr	Present	Present
	Rogelio A. Silva	Present	Present
MCLEAN			
OHIO			
UNION	Wallas N. Bell	.....	.....
WEBSTER			

THIRD DISTRICT

CALDWELL	Nathaniel H. Tolley	....	.....
CHRISTIAN	Emmanual J. Battoh	Present	Present
	Harry J. Dempsey	.....	.....
	J. Nicholas Terhune	.....	.....
CRITTENDEN	Scott R. Grahom	.....	.....
HOPKINS	Wallace R. Alexander	Present	Present
	James M. Bowles	Present	Present
	William H. Klompus	Present	Present
	Tristan K. Lineberry	Present	Present
LYON	Steve Hiland	.....	.....
MUHLENBERG	Joseph R. Boggess	.....	Present
TODD	Hank Bell, Jr	.....	.....
TRIGG			

FOURTH DISTRICT

BRECKINRIDGE			
BULLITT	James R. Cundiff	....	.....
GRAYSON	Roy A. Cave	Present	Present
GREEN			
HARDIN-LARUE	Arvil G. Catlett	.....	.....
	Ngo T. Nguyen Collard	.....	.....
	Marion A. Dougloss, Jr	.....	.....
	James T. Engle	Present	Present
	Lovegildo S. Garcia	.....	Present
	William C. Nash	.....	Present
HART	Keene M. Hill	.....	.....
MARION	David B. George	.....	Present
MEADE	Raymond L. Mathis	.....	.....
NELSON			
TAYLOR	Eugene H. Shively	Present	Present
WASHINGTON	Charles D. Howard	.....	.....

FIFTH DISTRICT

Jefferson	Arnold M. Belker	Present	. . .
	Charles J. Bisig, Jr	. . . . .	Present
	David H. Bizot	Present	Present
	Harold W. Blevins	. . . . .	Present
	Mark Bronner	Present	. . . . .
	Philip T. Browne	. . . . .	Present
	William C. Buschemeyer, Jr	. . . . .	Present
	Peter C. Campbell	. . . . .	Present
	Gregory J. Ciliberti	. . . . .	Present
	Stuart P. Cohen	. . . . .	. . . . .
	Samuel L. Cooper	. . . . .	Present
	John H. Doyle	Present	Present
	Rudy J. Ellis, Jr	Present	Present
	Samuel G. Eubanks, Jr	. . . . .	Present
	Mary E. Follot	. . . . .	Present
	John M. Farmer	. . . . .	. . . . .
	Marjorie R. Fitzgerald	. . . . .	Present
	Larry D. Flarman	. . . . .	Present
	Beverly M. Gaines	. . . . .	Present
	Henry D. Garretsan	. . . . .	. . . . .
	Katherine P. Garrison	. . . . .	. . . . .
	Kamla Gauri	. . . . .	Present
	Darius Ghazi	. . . . .	Present
	Linda H. Gleis	. . . . .	Present
	Cecil L. Grumbles	Present	Present
	Harold D. Haller	Present	Present
	B. Thomas Harter, Jr	Present	Present
	Albert B. Hoskins, III	Present	. . . . .
	Walter I. Hume	. . . . .	Present
	Barbara Sue Isaacs	. . . . .	Present
	John M. Koriba	Present	Present
	Arthur H. Keeney	. . . . .	Present
	Virginia T. Keeney	. . . . .	Present
	Donald R. Kmetz	Present	Present
	Robert W. Linker, III	Present	Present
	Robert L. McQuady, Jr	Present	Present
	Ralph C. Morris	. . . . .	Present
	William M. Moses	. . . . .	Present
	Hobert L. Pence	. . . . .	Present
	Thomas P. Ronkin	. . . . .	. . . . .
	James E. Redmon	Present	Present
	K. Thomas Reichard	Present	Present
	Sheldon B. Schiller	. . . . .	. . . . .
	George Randolph Schradt	Present	Present
	George R. Schrodt, Jr	Present	Present
	Kerry L. Short	. . . . .	Present
	Rebecca Terry	. . . . .	Present
	Edward D. Tillett	. . . . .	Present
	Robert S. Tillett	Present	Present
	Brenda I. Townes	Present	Present
	Daniel W. Vargo	. . . . .	. . . . .
	William P. VanderHoor	Present	Present
	Thomas R. Watson	. . . . .	. . . . .
	Peter H. Wayne, III	. . . . .	Present
	Samuel D. Weakley	Present	Present
	Barbara Weakley-Jones	Present	Present
	A. Franklin White, Jr	Present	Present
	Fred A. Williams, Jr	Present	Present
	Larry J. Wilson	Present	Present
	C. Milton Young, III	Present	Present
	Kenneth N. Zegart	Present	Present

SIXTH DISTRICT

ADAIR	Gary L. Portin	. . . . .	. . . . .
ALLEN	Earl P. Oliver	Present	Present
BARREN	Roy A. Gibson	. . . . .	. . . . .
	Hugh B.A. Lessenberry	. . . . .	. . . . .
BUTLER	Richard T. Wan	. . . . .	Present
CUMBERLAND	Samuel Lee Rice	. . . . .	. . . . .
EDMONSON	Omkar N. Bhatt	. . . . .	. . . . .
LOGAN	Lewis E. Martin	. . . . .	Present
METCALFE	Lawrence P. Emberton	. . . . .	. . . . .
MONROE	James E. Carter	. . . . .	Present
SIMPSON	Michael Pulliam	Present	Present
WARREN	Craig Alvin Beard	. . . . .	Present
	Jane R. Bramham	Present	Present
	John D. Gover	Present	Present
	James O. Willoughby	Present	Present

SEVENTH DISTRICT

ANDERSON	William P. McElwain	. . . . .	. . . . .
CARROLL	Benjamin Kutnicki	Present	Present
FRANKLIN	Joseph J. Dobner	. . . . .	Present
	Willis P. McKee	Present	Present
	Patricia K. Nicol	Present	Present
GALLATIN			
GRANT			
HENRY			
OLDHAM	Harold F. Funke	Present	Present
OWEN			
SHELBY	Ronald Waldridge	Present	Present
	David W. Wallace	. . . . .	. . . . .
SPENCER	William K. Skaggs	. . . . .	. . . . .
TRIMBLE	Roderick H. MacGregor	. . . . .	. . . . .

EIGHTH DISTRICT

BOONE	John D. Ammon	Present	Present
	Michael L. Robinson	. . . . .	Present
CAMPBELL	Charles L. Stephens	Present	Present
	Frederick A. Stine	Present	Present
	Steven M. Woodruff	Present	Present
KENTON	Gordon W. Air	Present	Present
	Charles F. Allnutt	Present	Present
	John Franklin Allnutt	Present	Present
	Thomas E. Bunnell	Present	. . . . .
	Harry W. Carter	Present	Present
	James H. Linne	. . . . .	. . . . .
	Theodore H. Miller	Present	Present
	Mary Redden Barowski	Present	Present
	B. Robert Schwartz	. . . . .	Present

NINTH DISTRICT

BATH			
BOURBON			
BRACKEN			
FLEMING	Glenn R. Womack	. . . . .	. . . . .
HARRISON	Donald R. Stephens	Present	Present
MASON	Audrey Spencer	. . . . .	. . . . .
NICHOLAS	Wendell R. Kingsolver	. . . . .	. . . . .
PENDLETON	Robert L. McKenney	. . . . .	Present
ROBERTSON			
SCOTT	James C. Contrill	Present	Present

TENTH DISTRICT

FAYETTE	John R. Allen	. . . . .	Present
	Ralph D. Caldroney	Present	Present
	Dorothy H. Clark	Present	Present
	John W. Collins	Present	Present
	Max A. Crocker	Present	Present
	Elvis S. Danaldson, Jr	Present	Present
	Harold T. Faulconer	Present	Present
	John M. Fox	Present	Present
	William F. Gee	. . . . .	. . . . .
	Bill H. Harris	. . . . .	Present
	Dennis B. Kelly	Present	Present
	Daniel E. Kenady, Sr	Present	Present
	John L. Kiesel	. . . . .	Present
	Bruce A. Lucas	. . . . .	Present
	William R. Meeker, Jr	Present	Present

	Andrew M. Moore, II		Present
	Franklin B. Moosnick	Present	.....
	Barbara A. Phillips	Present	Present
	John W. Poundstone	Present	Present
	Andrew R. Pulito	Present	Present
	Barry N. Purdom	....	Present
	Ellsworth C. Seeley	.....	Present
	David B. Stevens	Present	Present
	John D. Stewort	Present	Present
	Gory R. Wolloce	.....	Present
	Emery A. Wilson	Present	Present
JESSAMINE			
WOODFORD			

ELEVENTH DISTRICT

CLARK			
ESTILL			
JACKSON			
LEE	James B. Noble	Present	.....
MADISON	G. Irene Minor	Present	Present
	Richard A. Stone	Present	Present
MENIFEE			
MONTGOMERY	William R. Brodford	Present	Present
OWSLEY			
POWELL			
WOLFE	Paul F. Maddox	....	.....

TWELFTH DISTRICT

BOYLE	Dovid C. Liebschutz	Present	Present
	Scott B. Scutchfield	Present	Present
CASEY	Lewis E. Wesley	Present	.....
CLINTON	Michael Lee Cummings	.....	.....
GARRARD	Paul J. Sides	.....	Present
LINCOLN			
MCCREARY			
MERCER	Nick G. Dedman	Present	Present
PULASKI	Donald E. Brown	Present	Present
	James D. Crose	Present	Present
	Billy Jae Porson	Present	.....
ROCKCASTLE			
RUSSELL	H. Michael Oghio	Present	....
WAYNE	Dono L. Gibson	Present	Present

THIRTEENTH DISTRICT

BOYD	Kenneth R. Hauswald	Present	Present
	Howard B. McWharter	Present	Present
	John R. Potter	Present	Present
	Susan H. Prosher	.....	Present
CARTER			
ELLIOTT			
GREENUP	Chorles M. Rhodes	.....	Present
	Rojkumar K. Warrier	Present	.....
LAWRENCE	George P. Carter	Present	Present
LEWIS			
MORGAN	George R. Bellamy	.....	.....
ROWAN	Marc L. Halbrook	Present	Present

FOURTEENTH DISTRICT

BREATHITT			
FLOYD	Nicholas R. Jurich	...	.....
JOHNSON			
KNOTT			
LETCHER	Artie A. Botes	....	.....
MAGOFFIN			
MARTIN			
PERRY			
PIKE	Romonoroo V. Mettu	...	Present
	Roghuram S. Madur	Present	.....
	Oscor W. Thompson, III	Present	Present
	Mary L. Wiss	Present	Present

FIFTEENTH DISTRICT

BELL	Meredith J. Evons	...	.....
	Emonuel H. Roder	Present	Present
CLAY	Ira F. Wheeler	...	.....
HARLAN	Rochel R. Eubonk	Present	Present
	James K. Hurlocker	Present	Present
KNOX	Rogelio A. Acosto	Present	.....
LAUREL	Dovid W. Douglos	Present	Present
LESLIE			
WHITLEY	Fronk H. Cotron	Present	.....
	Jogdish S. Potil	.....	Present
	Cormel Wolloce, Jr	.....	Present

KMA Resident Physicians Section—Louro Spolding Moore	.....	Present
U of K Student Delegate—Paul McLaughlin	.....	Present
U of L Student Delegate—Kelo J. Lyons	.....	Present
KMA-HMSS-David R. Wotkins	....	.....

The informotion in the Roll Coll wos token from the ottendance record cards signed by the delegotes prior to the meetings of the House, September 24 ond September 26.

PROCEEDINGS

140th Annual Meeting
Kentucky Medical Association

September 24-27, 1990
Hyatt Regency - Commonwealth Convention Center
Louisville

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Reference Committees

(L to R) Reference Committee 1: Ralph D. Caldroney, MD, Lexington; David B. George, MD, Lebanon; Michele Redden-Borowski, MD, Covington, Chairman; G. Randolph Schrodt, MD, Louisville; Don R. Stephens, MD, Cynthiana.

Reference Committee 2: Harry W. Carter, MD, Covington; Daniel E. Kenady, MD, Lexington, Chairman; Larry J. Wilson, MD, Louisville; Kela Lyons (MSS), Louisville; Ronald Waldridge, MD, Shelbyville.

Reference Committee 3: John T. Houston, MD, Owensboro; Scott B. Scutchfield, MD, Danville; Donald E. Brown, MD, Somerset; Samuel G. Eubanks, MD, Louisville; John D. Stewart, MD, Lexington, Chairman.

Reference Committee 4: Andrew R. Pulito, MD, Lexington; K. Thomas Reichard, MD, Louisville; David W. Douglas, MD, London, Chairman; Laura Spalding Moore, MD, Louisville; J. Michael Pulliam, MD, Franklin.

Reference Committee 5: Frank H. Catron, MD, Corbin; John R. Potter, MD, Ashland; Thomas K. Slabaugh, MD, Lexington, Chairman; James O. Willoughby, MD, Bowling Green; Kerry L. Short, MD, Louisville.

Reference Committee 6: James C. Cantrill, MD, Georgetown; John W. Collins, MD, Lexington; William P. VonderHaar, MD, Louisville, Chairman; Ronald M. Johnson, MD, Owensboro; James T. Engle, MD, Elizabethtown.

The Joseph Ezra Wells, MD Memorial Meeting of the Kentucky Medical Association

***Digest of Proceedings of the Regular Session of the**

House of Delegates

Danny M. Clark, MD, Somerset
Speaker of the House, Presiding

First Meeting
September 24, 1990

Danny M. Clark, MD, Speaker of the House of Delegates, called the first Meeting of the 140th Session of the KMA House of Delegates to order at 9:00 AM on Monday, September 24, 1990 at the Hyatt Regency Hotel, Louisville, Kentucky. He introduced the new Vice Speaker, C. Kenneth Peters, MD, Jeffersontown, and KMA's Legal Counsel, Charles J. Cronan, IV, Louisville.

Following the invocation given by Harold L. Bushey, MD, Barbourville, the Chairman of the Credentials Committee, C. Milton Young, III, MD, Louisville, reported that a quorum was present. It was noted that additional Credentials Committee members were Gordon W. Air, MD, Crestview Hills; and Don R. Stephens, MD, Cynthiana.

A motion was made, seconded, and carried to approve the Minutes of the 1989 Session of the House of Delegates as published in the December 1989 *Journal of the Kentucky Medical Association.*

S. Randolph Scheen, MD, Louisville, Secretary-Treasurer, reported that the Scientific Session would begin at 8:30 AM on Tuesday, and the President's Luncheon would be held on Wednesday, at which time the new President would be installed. Doctor Scheen reminded the Delegates that Reference Committees would convene at 2 PM on Monday, and that Reference Committee 3 would hold a special hearing on Certificate of Need issues at 3 PM. He then asked the Delegates to stand for a moment of silence in memory of KMA members who had died since the 1989 Annual Meeting.

Speaker Clark announced that the Rules Committee had prepared a booklet outlining the rules the House should follow in its deliberations.

Esther Jansing, immediate past president of the Auxiliary to KMA, presented AMA-ERF checks comprised of funds the Auxiliary had raised to benefit Kentucky's medical schools. Emery A. Wilson, MD, Dean, accepted a check for $18,514.23 on behalf of the University of Kentucky College of Medicine; and Donald R. Kmetz, MD, Dean, accepted a check for $27,378.73 on behalf of the University of Louisville School of Medicine.

KMA President Nelson B. Rue, MD, Bowling Green, presented the Educational Achievement Award to Loman C. Trover, MD, Madisonville. Doctor Rue then presented to KMA a framed print of "The Doctor," by Sir Luke Fildes, which was accepted on behalf of KMA by Preston P. Nunnelley, MD, President-Elect, and Robert G. Cox, Executive Vice President. In his remarks, Doctor Rue noted that the print symbolized the essence of medicine — the bond between the physician and patient — that physicians must strive to reinforce in the current climate of outside intervention into the doctor/patient relationship.

Speaker Clark noted that the Board of Trustees had introduced three special Resolutions that morning. The Resolutions were read, and a motion was made, seconded, and carried to adopt each as written:

Resolution

Testimonial to Joe A. Wallace and Cecil Dulin Wallace
Board of Trustees

WHEREAS, Joe A. Wallace and Cecil Dulin Wallace (Mr. and Mrs. Joe A. Wallace) have bequeathed upon their deaths

Editorial Note: A tape recording was made of the two Meetings of the House of Delegates, and any member who wishes to examine the transcript of these proceedings may visit the Headquarters Office and listen to the recordings.

to KMA the Cambus-Kenneth farm, the summer home of the pioneer surgeon Ephraim McDowell, MD, and

WHEREAS, the Wallaces and the officers and Board of Trustees of the KMA have formed the Ephraim McDowell Cambus-Kenneth Foundation, Inc, to serve as the repository and permanent corporation to preserve and protect for all time this historical place, and

WHEREAS, the purposes of the Foundation "are exclusively for charitable and educational purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance, including but not limited to the McDowell House and Apothecary Shop in Danville, Kentucky, and medically related charitable and educational purposes, and such further charitable and educational purposes as are permitted to corporations" pursuant to federal and state laws, and

WHEREAS, this unselfish and extraordinary gift by the Wallaces represents one of the largest known contributions ever presented to a medical organization by private individuals, and

WHEREAS, by their benevolence they have reunited under one entity the homes and property of one of Kentucky's greatest sons and the father of abdominal surgery, now therefore be it

RESOLVED, that the KMA House of Delegates expresses its gratitude and appreciation to Joe A. Wallace and Cecil Dulin Wallace for this valuable and historical gift and for the opportunity to preserve this segment of history surrounding the life of Ephraim McDowell, and be it further

RESOLVED, that this Resolution be made a permanent part of the record of the House of Delegates and that copies be presented to Joe A. Wallace and Cecil Dulin Wallace.

Resolution

Memorial to John E. Trevey, MD
Board of Trustees

WHEREAS, John E. "Jack" Trevey, MD, died on June 28, 1990, following a professional and political career distinguished by leadership and service, and

WHEREAS, Doctor Trevey was a long-time member of the KMA House of Delegates and held many offices in the Fayette County Medical Society, including President, during his years of occupational medicine practice in Lexington, and

WHEREAS, Senator Trevey served ably and with distinction for 14 years in the Kentucky General Assembly as both state Representative and Senator, and

WHEREAS, he was a forceful and effective advocate of patients, physicians, and medicine in the halls of government and in the Chambers of the Kentucky General Assembly, and

WHEREAS, his sudden death leaves Kentucky without one of its staunchest advocates of medical practice and the sanctity of the physician/patient relationship, now therefore be it

RESOLVED, that the Kentucky Medical Association House of Delegates express its profound sorrow at the loss of Doctor Trevey, and be it further

RESOLVED, that the House of Delegates of the Kentucky Medical Association recognize and record its deep appreciation for the extraordinary contributions of Doctor Trevey to his patients, profession, and community, and be it further

RESOLVED, that this Resolution be made a permanent part of the record of the House of Delegates and a copy be sent to Doctor Trevey's family as an expression of respect and sympathy.

Resolution

Tribute to Ryan White
Board of Trustees

WHEREAS, a whole population was deeply saddened by the news of the loss of Ryan White, and

WHEREAS, this exemplary young man exhibited great courage in the face of adversity, and maturity and stature beyond his years, and

WHEREAS, through his efforts and example national attention became focused on educational, medical, and social aspects regarding AIDS, resulting in intensified treatment efforts and significant social enlightenment, and

WHEREAS, despite the brevity of his years, Ryan White made a profound contribution to the country's social ethics and developed his struggle with affliction into a tribute to the human spirit, now therefore be it

RESOLVED, that the KMA House of Delegates recognizes and commends the accomplishments and contributions of Ryan White, and be it further

RESOLVED, that the House of Delegates commends and esteems the family and large circle of friends of Ryan White for their unwavering support and encouragement, and be it further

RESOLVED, that Ryan White's efforts served as a memorial to the triumph of the basic rights of individuals to receive appropriate medical care and social attention, regardless of their malady, and be it further

RESOLVED, that this Resolution become a permanent part of the archives of this organization, thence to serve as a source of inspiration to all present and future members of this Association as a hallmark of service to human needs.

Speaker Clark introduced the officers who presented their Reports. Each of the Reports was assigned to a Reference Committee as noted:

Report Number		Reference Committee
1	Report of the President Nelson B. Rue, MD, Bowling Green	1

Report Number		Reference Committee
2	Report of the President, Auxiliary to KMA Esther Jansing, Owensboro	1
3	Report of the President-Elect Preston P. Nunnelley, MD, Lexington	1
4	Report of the Speakers, House of Delegates Danny M. Clark, MD, Somerset C. Kenneth Peters, MD, Louisville	1
5	Report of the Chairman, Board of Trustees William B. Monnig, MD, Edgewood	1
6	Report of the Secretary-Treasurer S. Randolph Scheen, MD, Louisville	1
7	Report of the Editor A. Evan Overstreet, MD, Louisville	1
8	Report of the Delegates to AMA Donald C. Barton, MD, Corbin	1
9	Report of the Executive Vice President Robert G. Cox, Louisville	1
10	Kentucky Physicians Care Operating Committee Russell L. Travis, MD, Lexington	1
11	KMA Physicians Services, Inc. William B. Monnig, MD, Edgewood	1
12	Kentucky Medical Insurance Company Ballard W. Cassady, MD, Pikeville	1
13	Scientific Program Committee James A. Baumgarten, MD, Louisville	2
14	Scientific Exhibits Committee Richard A. Kielar, MD, Lexington	2
15	Continuing Medical Education Committee Larry P. Griffin, MD, Louisville	2
16	Council for Continuing Medical Education James A. Baumgarten, MD, Louisville	2
17	Cancer Committee Clinton C. Cook, III, MD, Louisville	2
18	Emergency Medical Care Seminar Planning Committee E. Truman Mays, MD, Somerset	2
19	Physician Manpower Committee Robert R. Goodin, MD, Louisville	2
20	Interspecialty Council Bob M. DeWeese, MD, Louisville	2
21	Committee on Faculty Physicians Robert R. Goodin, MD, Louisville	2
22	Hospital Medical Staff Section Donald J. Swikert, MD, Florence	2
23	Maternal Mortality Study Committee John W. Greene, Jr., MD, Lexington	3
24	Committee on National Legislative Activities Donald C. Barton, MD, Corbin	3
25	Committee on State Legislative Activities Wally O. Montgomery, MD, Paducah	3
26	Committee on Impaired Physicians Burns M. Brady, MD, Louisville	3
27	Committee on Care for the Elderly John C. Wright, II, MD, Louisville	3
28	Committee on Medical Insurance and Prepayment Plans Earl P. Oliver, MD, Scottsville	4
29	Committee on Claims and Utilization Review K. Thomas Reichard, MD, Louisville	4
30	PRO Advisory Committee James M. Bowles, MD, Madisonville	4
31	Committee to Investigate Changing Trends in Medicine Robert R. Goodin, MD, Louisville	4
32	Committee on Maternal and Child Health Danny M. Clark, MD, Somerset	5
33	Technical Advisory Committee on Physician Services (Title XIX) Harold L. Bushey, MD, Barbourville	5
34	Committee on Community and Rural Health Ardis D. Hoven, MD, Lexington	5
35	Committee on School Health, Physical Education, and Medical Aspects of Sports R. Quin Bailey, MD, Danville	5
36	Judicial Council Will W. Ward, MD, Louisville	6
37	Rural Kentucky Medical Scholarship Fund Carolyn H. McKinley, MD, Glasgow	6
38	Physician-Attorney Liaison Committee Lynn L. Ogden, MD, Louisville	6
39	Membership Committee Harold D. Haller, Sr, MD, Louisville	6
40	Committee on Constitution and Bylaws R. J. Phillips, Jr, MD, Owensboro	6
41	Young Physicians Steering Committee Donald J. Swikert, MD, Florence	6
42	Medical Student Section Baretta Casey, Lexington	6
43	Resident Physicians Section W. Ford Threlkeld, MD, Madisonville	6
44	Ephraim McDowell Cambus-Kenneth Foundation David W. Kinnaird, MD, Louisville	6

Ad Hoc Committee Reports

Ad Hoc Committee to Study Advocacy Programs Bob M. DeWeese, MD, Louisville	1
Ad Hoc Committee on Professional Liability Insurance Wally O. Montgomery, MD, Paducah	3
Ad Hoc Committee on Quality of Care K. Thomas Reichard, MD, Louisville	4

New Business

New Business of the House of Delegates was assigned to the Reference Committee indicated:

Resolution	Submitted By	Subject	Reference Committee
A	Northern Kentucky Medical Society, Inc	Medical Use of Laser Technology	2
B	Board of Trustees	Recognition of Pfizer, Inc	1
C	Board of Trustees	CME Activities	2
D	Board of Trustees	Certificate of Need	3
E	Oris Aaron, MD, Columbia	Inequitable Reimbursement	4
F	Fayette County Medical Society	Living Wills/Health Care Surrogates	3
G	Fayette County Medical Society	Use of Seat Belts	6
H	Jefferson County Medical Society	Election of Insurance Commissioner	Withdrawn
I	Jefferson County Medical Society	Tax on Liability Insurance Premiums	1
J	Jefferson County Medical Society	AMPAC/KEMPAC Membership Drive	6
K	Jefferson County Medical Society	KEMPAC Endorsements	6
L	Fayette County Medical Society	Medical Use of Laser Technology	2
M	Jefferson County Medical Society	Physician Candidates for Public Office and Third-Party Positions	3
N	Jefferson County Medical Society	AMA Accountability	1
O	Hardin-LaRue County Medical Society	Centralized Database for all Prescribed Medications and Drugs in the Commonwealth of Kentucky	3
P	KMA Resident Physicians Section	Local Seat Belt Laws	6
Q	KMA Resident Physicians Section	Regulation of Water Jet Skis	6
R	KMA Resident Physicians Section	Encouragement of Breastfeeding	5
S	Floyd County Medical Society	Use of Steroids and Amino Acids	5
T	Floyd County Medical Society	Sentinel Medical Review Organization	4
U	Floyd County Medical Society	Membership Dues	6
V	Robert N. Alexander, MD, Pineville	Equitable Medicaid Payments	5
W	Jefferson County Medical Society	Medicare Supplement Regulations	5
X	Jefferson County Medical Society	Gun Control	6
Y	Jefferson County Medical Society	Radon Action Week	2
Z	Fayette County Medical Society	Breastfeeding	5
AA	Board of Trustees	Medical Use of Laser Technology	2

Doctor Peters announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. He reminded the Delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning.

The names of the members of the Nominating Committee were announced: Charles F. Allnutt, MD, Edgewood, Chairman; Bill H. Harris, MD, Lexington; Willis P. McKee, Jr, MD, Frankfort; George R. Schrodt, Jr, MD, Louisville; and Howard B. McWhorter, MD, Ashland.

Vice Speaker Peters adjourned the first meeting at 10:28 AM.

Second Meeting
September 26, 1990

Speaker Clark called the second meeting of the 1990 Session of the KMA House of Delegates to order at 7:15 PM on Wednesday, September 26, 1990. Paul J. Parks, MD, Bowling Green, gave the invocation, and Don R. Stephens, MD, a member of the Credentials Committee, reported that a quorum was present. Doctor Clark noted that John R. Potter, MD, Ashland; Don R. Stephens, MD, Cynthiana; Larry J. Wilson, MD, Louisville; and Kela Lyons, Louisville (Medical Student Section), would serve as Tellers during the Meeting.

Secretary-Treasurer Scheen recognized guests from neighboring state medical associations who had attended the Annual Meeting. Included were James H. Andersen, MD, President, Illinois State Medical Society; John A. Devany, MD, President, Ohio State Medical Association; Michael W. Stump, MD, President, West Virginia Medical Association; John A. Owen, Jr, MD, President-Elect, Medical Society of Virginia; and C. Dyke Egnatz, MD, Speaker, House of Delegates, Indiana State Medical Association.

William B. Monnig, MD, Chairman of the Board of Trustees, made a motion, on behalf of the Board, that William T. Watkins, MD, Somerset, be elected to a four-year term on the Judicial Council. The motion was seconded from the floor and carried.

President Rue stated that he had the pleasure of introducing a special guest, Dr C. John Tupper, President of the American Medical Association. Doctor Tupper noted that there exists a new spirit of pride within the AMA, and that membership is up by 1,600 members. He noted that he was pleased that the KMA Board had endorsed the AMA's "Health Access America" proposal, and hoped the Delegates would take the same action.

Doctor Tupper showed a videotape from the television show, "Prime Time Live," regarding what the AMA considered to be undue harassment of several physicians who participate in the Medicare Program by Richard Kusserow, Inspector General of the US Department of Health and Human Services. Doctor Tupper noted that the AMA had mobilized its resources to act quickly to call for the resignation of Mr. Kusserow, including petitioning President George Bush to remove the Inspector General from his position.

Chairman Monnig stated that Dr Tupper had brought before the House a challenge that needed to be addressed immediately, and, in response, introduced a Resolution on behalf of the Board of Trustees. A motion was made, seconded, and carried to adopt the following Resolution:

Resolution CC

Resignation of Inspector General, Department of Health and Human Services
Board of Trustees

WHEREAS, the Office of the Inspector General, US Department of Health and Human Services, is in charge of oversight of physician involvement in the Medicare program, including the sanction process, and

WHEREAS, the Kentucky Medical Association supports the elimination of substandard physicians who abuse the program, and

WHEREAS, the incumbent Inspector General, Richard Kusserow, who presides over the physician sanction process, is perceived to have ignored, and fought against, principles of fairness that are routine to the American administrative and judicial system, and

WHEREAS, competent and honest physicians have been damaged and more have been unnecessarily harassed, and

WHEREAS, in order to obtain the most elementary protection for physicians accused of misconduct, several suits have been filed against Mr. Kusserow by the American Medical Association, the California Medical Association, and other professional societies, and

WHEREAS, Mr. Kusserow's own state enforcement partners, the National Association of Attorneys General, have publicly protested his practices, now therefore be it

RESOLVED, that this Association join with the AMA in calling for the resignation of Mr. Richard Kusserow, and be it further

RESOLVED, that KMA advise the Kentucky Congressional Delegation of this position and seek their assistance in persuading President Bush to ask Mr. Kusserow to resign.

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 1

Michele Redden-Borowski, MD, Covington, Chairman

1. Report of the President
2. Report of the President, Auxiliary
3. Report of the President-Elect
4. Report of the Speakers, House of Delegates
5. Report of the Chairman, Board of Trustees, ***except*** for the following:
   Report of the Ad Hoc Committee on Professional Liability Insurance (Referred to Reference Committee No. 3)
6. Report of the Secretary-Treasurer
7. Report of the Editor
8. Report of the Delegates to AMA
9. Report of the Executive Vice President
10. Report of the Kentucky Physicians Care Operating Committee
11. Report of KMA Physicians Services, Inc
12. Report of the Kentucky Medical Insurance Company
    Resolution B — Recognition of Pfizer, Inc (Board of Trustees)
    Substitute Resolution 1 — Tax on Liability Insurance Premiums (Jefferson County Medical Society) Resolution N — AMA Accountability (Jefferson County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 1 reviewed the following items and recommends they be filed, as indicated, by consent of the House, without discussion:

3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed
9. Report of the Executive Vice President — filed
11. Report of KMA Physicians Services, Inc — filed
12. Report of the Kentucky Medical Insurance Company — filed

Mr Speaker, Reference Committee No. 1 recommends adoption of the Consent Calendar as a whole.

Report of the President-Elect

It is my distinct privilege to report to you as President-Elect. You have provided me with a signal honor in electing me, and I humbly pledge my best efforts in your behalf.

During the past year, I have been most fortunate in being able to be a part of this Association's activities and at the center of the major events that have affected our organization. I have had the opportunity to witness firsthand the organization's operation and effectiveness, and I am most pleased to be able to play a part.

Throughout the year, I have had the opportunity to not only observe the actions of the Board of Trustees and the officers, particularly President Nelson Rue and Board Chairman William Monnig, but I have also been able to represent the Association a number of times. The two areas that stand out in my mind are in the state Legislature and at the AMA level.

In the state Legislature, I am deeply impressed by KMA's efforts, and particularly those of the Chairman, Wally O. Montgomery, MD. As you will learn elsewhere in these reports, KMA routinely follows over 100 bills that directly affect medicine, and Wally and the legislative staff accomplish amazing results, given the overwhelming number of bills and interrelated issues with which they must deal. Equally overwhelming are the issues and materials confronted at the AMA level. It is probably true with every national organization, but

it seems that AMA issues literally run the gamut of health-related, and sometimes social, affairs that affect medicine. To be a part of those efforts is tantamount to helping guide medicine's affairs in this country.

While performing these duties on your behalf, I have developed an impression that medicine has had so many detractors and opponents for so long that we have lost sight of the positive aspects of our profession, our careers, and the worth of our daily lives. What may be seen as a loss of the sense of self-worth is shown very forcefully in such issues as decreasing medical school enrollment and the general attitudes of physicians as we approach our day-to-day practices.

This report is not the appropriate forum for addressing all of the forces that influence the diminution of medicine. However, it is proper for us to begin cataloging all of the positives that medicine has brought to us as individuals and to our society. The theme of this year's scientific program is "Pride in Medicine," and I hope this can be a sound step toward redefining the proper role medicine plays. In the past decade, medicine and physicians have increasingly been taken to task for all of the ills of the medical care system. Certainly, we bear responsibilities, but rather than being the root cause of those problems, we are, in fact, the answer.

This adversarial situation has influenced us to lose sight of the fact that the center of the medical care delivery system in this country is quality and, ironically, that is seldom questioned. Rather than say things from a defensive posture, we need to realign our outlook. What is wrong with the medical care delivery system is not medicine, nor physicians.

It is my hope that I can adequately carry this message in the coming year and fulfill the demands of the office of President and your representative. Following in the footsteps of the able leadership of Nelson Rue will not be an easy task, but I will certainly give my very best effort. I deeply appreciate the trust that has been given me, and urge your questions, comments, and support.

Preston P. Nunnelley, MD
President-Elect

Report of the Speakers, House of Delegates

This 140th Annual Meeting will witness the discussion of a number of significant matters, and it is our intent to help assure open and frank debate. To assist with this goal, we would urge that you share the materials provided to you with other members in your district so you can represent their views in the meetings of the House, and your Speakers look forward to an informative and productive session.

Every effort has been made to provide you with these materials on a timely basis, although last-minute matters are anticipated and can be dealt with. However, it is most important that full dissemination be made to other members by Delegates so that our meetings can be as representative of the membership as possible.

This meeting will constitute our first year in office as your new Speaker and Vice Speaker, and we would like to assure you of our preparations and deep commitment to serving you. Any comments or questions that can be given to assist us are most strongly welcomed. During the Annual Meeting, your Speakers will be available to any Delegate or member who seeks our counsel or aid, and we anticipate a productive session.

Danny M. Clark, MD
Speaker, House of Delegates

C. Kenneth Peters, MD
Vice Speaker, House of Delegates

Report of the Editor

The *Journal of the Kentucky Medical Association* is a premier publication. Your Editorial Board and staff strive to maintain it as a creditable vehicle for physician communication and for helping to educate physicians and their patients. The *Journal* continues to serve as an open forum for the exploration and discussion of issues vital to the physicians of Kentucky and remains a popular and important benefit of membership in the Association. Every endeavor is made to make it attractive, interesting, and worthy of the profession.

Ever seeking to stimulate writing by Kentucky physicians and to encourage the medical schools, hospitals, clinics, and guests to contribute to its pages, our publication continues to be multi-faceted. During 1989-90 the *Journal* featured 23 original scientific articles representing the efforts of 82 different authors; 7 Grand Rounds contributions through the commendable efforts of the University of Kentucky and University of Louisville medical schools; reports from Clinical Notes on Aging; the entire proceedings of the 1989 KMA Annual Meeting; several book reviews written with the concise, thoughtful, and interesting insights of Assistant Scientific Editor Stephen Z. Smith, MD; as well as numerous editorials and articles discussing medical issues of interest to our membership.

In January the *Journal* published the "1990 KMA Legislative Handbook," a comprehensive collection of legislative information designed to equip KMA members with information necessary to effectively communicate with fellow members and legislative staff, and to seek support for KMA's legislative positions from members of the Kentucky General Assembly. This was followed in June with publication of the "1990 KMA Legislative Report," an overview of legislation relating to health/medical issues considered by the 1990 KGA. These endeavors began with a "Handbook" in 1988, and we

anticipate such publications in successive legislative years. The 1990 "Handbook" is a handsome volume which received numerous compliments from members and several state associations.

During the past year, the Editorial Board approved the initiation of two new features: (1) AMA Delegation articles to keep KMA membership abreast of the tremendous volume of information and policy making that is accomplished on their behalf at the AMA House and (2) reviewed articles solicited by the Impaired Physicians Committee.

A medical journal cannot function without critical evaluation of the manuscripts it receives. Each of our editors is to be commended for his or her unique contribution and time-consuming service in this endeavor. For exemplary service to the *Journal*, I wish to personally thank the other members of our Board: Doctors Paul C. Grider, Scientific Editor; Stephen Z. Smith, Assistant Scientific Editor; and McHenry S. Brewer, Martha Keeney Heyburn, and Milton F. Miller, Assistant Editors.

With the death of Assistant Editor David L. Stewart, MD, on November 24, 1989, the *Journal* and the Association suffered a great loss. His contributions were invaluable, and he will be missed. Perhaps our tribute can best be expressed in the words of Scientific Editor Paul C. Grider, MD, as taken from his memoir of Doctor Stewart in the January issue of the *Journal*, "He was as good a clinician as I've ever seen. . . . He has left us with a role model of excellence as a person, husband, father, physician, that few of us will match. Those of us who knew him will always be in his debt."

The Editorial Board is in the process of nominating an editor to fill the vacancy created by Doctor Stewart's death.

The costs of the *Journal* continue to be closely monitored. Contracting with The Ovid Bell Press, Inc, Fulton, Missouri, has proven to be a prudent arrangement. This printer provides a high-quality product at a reasonable cost. The backbone of its operation is in printing 13 state association journals, as well as numerous medical specialty publications; so it cooperates fully with the medical industry. Local advertising remains strong, but national advertising is soft. However, we are pleased to report that of the 31 state journals represented by the State Medical Journal Advertising Bureau (SMJAB), our *Journal* is one of only five that showed an increase in 1989 over 1988. SMJAB is in a transition period, with a newly elected chairman, more effective sales representation, and a concerted effort to improve the overall operation. If our 1990 SMJAB income continues at its current pace, we should realize a 20% increase in national advertising revenue for the year. Production costs have remained relatively stable, but postal rates continue to increase.

During the past year, I represented our Editorial Board at the American Medical Writers Conference (AMWA) in Boston. The four-day event consisted of a very comprehensive presentation for medical writers in preparing, editing, and publishing quality scientific publications. During a State/Small Journal Editors Forum, nationally known design and editorial consultants, Brady & Paul Communications, critiqued the design of several journals previously submitted for review. Our *Journal* was included and was used several times in their slide presentation. While this was not a contest, we are pleased to report that our *Journal* received all positive comments, including "The Kentucky publication is really beginning to fall together from cover to cover," "classy," and "somewhat formal." Brady & Paul are the geniuses behind the graphic redesign of many national-circulation magazines, so their critique was important to the future direction of our design. The Editorial Board also welcomes our readers' advice and counsel in our efforts to constantly refine and improve the *Journal*. We are listening.

The Editorial Board has been pleased with the progress of the *Journal* and the increased interest shown by the membership. We invite your frequent submissions of scientific articles, continued use of Letters to the Editor as a medium of exchange, as well as updates on the newsworthy activities and professional accomplishments of both KMA members and members of the Auxiliary to the KMA.

As the *Journal* enters its tenth decade, it is dedicated to carrying forward a past tradition of excellence and to preparing to meet the inevitable scientific and professional challenges of the next century.

A. Evan Overstreet, MD
Editor

Report of the Delegates to AMA

The AMA House of Delegates was a forum for the discussion of a number of significant issues facing medicine. At both the Interim Meeting in December and the Annual Meeting held this past June, you were very ably represented by the Delegation you elected.

In January, the Kentucky Delegation seats were revised. We noted with regret the retirement of Carl Cooper, Jr, MD, Bedford, as Alternate, but were pleased to welcome Larry Franks, MD, Paducah, as a new Alternate, and Harold L. Bushey, MD, Barbourville, who moved from Alternate to Delegate. The other members of the Delegation are: Kenneth P. Crawford, MD, Louisville, Delegate; Wally O. Montgomery, MD, Paducah, Delegate; Robert R. Goodin, MD, Louisville, Alternate; Ardis D. Hoven, MD, Lexington, Alternate; and Donald J. Swikert, MD, Florence, Alternate.

You were also represented at AMA meetings this year by President Nelson B. Rue, MD; President-Elect Preston P. Nunnelley, MD; Board Chairman William B. Monnig, MD; and Immediate Past President Bob M. DeWeese, MD. Kentucky had further voice through the Young Physicians Section, represented by Drs Nancy Swikert, J. Gregory Cooper, and Michael Oghia; and the Resident Physicians Section, represented by Vaughn Payne, MD. We were pleased to note the

success of our Medical Student Section. Judy Linger, a student from the University of Kentucky, was elected to chair the Medical Student Section Governing Council. Kentucky students were further represented at the meetings by: Phil Budzenski, Cathy Soldo, Baretta Casey, and Paul McLaughlin from the University of Kentucky; and Joel Shanklin, Mark Distler, Christa-Marie Singleton, Kela Lyons, and Terry Cleaver from the University of Louisville.

At the June meeting, Kentucky was distinguished by the presentation of the AMA Citation of a Layman Award to Lt Governor Brereton Jones, nominated by the KMA for his work in helping to initiate the Kentucky Physicians Care Program. Lt Governor Jones received the award in person and complimented KMA and the Kentucky physicians who participate on the program.

Just prior to the Annual Meeting, James S. Todd, MD, was named as the chief executive officer by the Board of Trustees to replace James A. Sammons, MD. Doctor Sammons resigned after discovery of some financial errors that occurred through his office, and a number of steps were undertaken and confirmed by the House to prevent further problems. Doctor Todd is known to most members of the Delegation, and he has our full faith and support.

One of the major issues facing the AMA House of Delegates and the entire organization this year was the Health Access America program. This is a many-faceted program developed by the AMA and other organizations to restructure health care delivery. It calls for legislative, regulatory, and social revisions to a significant degree. Many of the efforts called for in the 22-point program have already been undertaken in Kentucky, and it is felt that we are somewhat ahead in this area.

Some of the highlights of issues addressed this year include:

- The introduction of HR 4475, the Physician Regulation Relief Amendment of 1990 or Medicare "anti-hassle" bill, which would alleviate some of the administrative burdens physicians now face. Currently, Kentucky has three cosponsors of this bill, and we anticipate that more will join.
- HR 747, which would restore student loan deferments and has six Kentucky cosponsors.
- The "125% Rule," which would impose balance billing limits of 125% of the allowable Medicare charge beginning in 1991, and attempts to delay this for a year.

Other Medicare-related issues included support for litigation challenging maximum allowable charges; support for Medicare volume performance standards, as opposed to expenditure targets; and support for implementation of the Resource-Based Relative Value Scale.

Additional issues were to encourage states to strengthen drunk driving laws; oppose the Health Care Financing Administration's denial of reimbursement for assistant surgeons at cataract surgeries; a lot of effort directed toward fair implementation of the Clinical Laboratory Improvement Act of 1988; support for the development of protocols for medical students exposed to contaminated fluids; and revised policies on AIDS guidelines.

This year the Delegation got approval from the Board of Trustees to print a series of articles in the KMA *Journal*. Each member of the Delegation is assigned to the same Reference Committee continuously and, as a result, develops considerable expertise on the range of issues assigned to that Reference Committee. The purpose of the articles is to disseminate some of that information routinely to the membership.

On behalf of the Delegation, including our "auxiliary" members — students, residents, young physicians, and county medical society representatives, I would like to thank you for the pleasure of serving you and the Association. Our work is quite detailed and sometimes tedious, but extremely important in helping to chart the course of the AMA. A final thanks is in order to the Board of Trustees for its support and trust and, most particularly, to the officers, who have given unselfishly of their time, counsel, and wisdom.

Donald C. Barton, MD
Senior Delegate

Report of the Executive Vice President

In lieu of the annual narrative report, I thought it might be interesting to list some of KMA's major accomplishments during the 1989-90 Association year.

While specific 1989-90 accomplishments are highlighted, recognition should be given to the thousands of volunteer hours of various committee members who contribute so freely of their time. Standing committees serve in various external and internal capacities at KMA, and it is to these committee members we pay special tribute.

The following highlights 1989-90 accomplishments:

State Legislative Activities

We had an unprecedented Legislative Session. The House of Delegates adopted 35 legislative directives, and the 1990 Kentucky General Assembly enacted 24 KMA proposals, including:

- Protection of retirement plans from judgement.
- The entire House of Delegates package of recommendations re: AIDS.
- On three occasions, defeated attempts to include physicians' offices under Certificate of Need.
- Readopted amended Confidentiality of Peer Review statutes to meet objections of Kentucky's Supreme Court.
- Adopted utilization review guidelines to address abuses of the UR concept and provide protection to patients from overzealous claims review agents representing

peer review organizations and insurance companies.
- Increased Medicaid funding and legislation requiring periodic updating of physician profiles.

Gifts

- Arranged for the future acceptance of the generous gift of Ephraim McDowell's summer home and surrounding 550 acres from Mr and Mrs Joe Wallace upon their deaths. The Cambus-Kenneth Farm, along with Ephraim McDowell's Danville home, apothecary shop, and land, were deeded to the Ephraim McDowell Cambus-Kenneth Foundation, Inc.
- Received $15,000 from members in donations to KMA's Benevolent Fund.

Litigation

- Filed an amicus curiae brief in support of a KMA member who had peer review committee records subpoenaed.
- Joined in a lawsuit supporting present statutes which permit associations to nominate members to various state government boards and commissions.
- Petition was made and granted to file an amicus curiae brief in a case where the physicians and guardian concluded that extraordinary means of prolonging a nursing home patient's life should be discontinued. The nursing home sought a declaration of rights regarding patients who are unable to make their own decisions.

Kentucky Physicians Care Program

- Certified eligibility of 7,073 new patients. (Total since 1985 — 73,444)
- Referred 4,100 patients to participating physicians. (Total since 1985 — 32,280)
- Received 9,550 phone requests. (Total since 1985 — 71,150)
- Signed 54 new participating physicians. (2,332 participating physicians)
- Kentucky Pharmacists Association joined the Health Care Access Foundation which now provides physician, hospital, and pharmacy services.
- Pfizer Laboratories/Roerig Corporation agreed to provide $1 million in free pharmaceuticals.

Seminars/Meetings

KMA conducted or cosponsored 27 seminars/meetings registering over 5,300 attendees. Seminars conducted in 1989-90 include:

- 20th Annual KMA Emergency Medical Care Seminar
- Sixth annual meeting of KMA Hospital Medical Staff Section
- Two Medicare Update seminars
- Three Insurance Coding seminars
- How To Get Started In Practice Seminar
- Medical Office Management Institute — a four-day seminar cosponsored with Jefferson County Medical Society
- Ten Regional Sports Symposiums for Kentucky high school athletic coaches
- KMA Annual Meeting
- State Legislative Seminar
- Impaired Physicians Forum
- CME Seminar

Surveys

Surveying membership attitudes and needs is an ongoing process at KMA, and we conducted the following surveys:

- Surveyed newly licensed physicians to examine factors motivating physicians to choose either rural or urban practice.
- Surveyed physician offices' policies and personal views on smoking.
- Conducted ten CME on-site surveys.
- Surveyed physicians on various quality of care issues.

New Programs/Activities

- Organized the Kentucky Geriatrics Society — a specialty group.
- Developed a slide show/packet of information encouraging high school students to choose medicine as a career.
- Developed, printed, and distributed 4,000 copies of *Syllabus of Sports Injury Care for the Kentucky High School Coach*, a 65-page handbook, to Kentucky's high school coaches.
- Updated brochures on adult abuse and distributed to physicians, appropriate institutions, and government agencies.
- Implemented the "Doctoring Under the Influence" program, a voluntary proposal for hospitals and other medical facilities to deal with impaired physicians.
- Joined with medical schools to establish an impairment program to expand substance abuse identification and disseminate treatment information.
- Revitalized the voluntary CME effort, refined and improved the accreditation process, and issued a revised mission statement.
- Republished and mailed KMA's "Identifying Child Abuse" brochures to appropriate agencies, schools, providers, etc.
- Developed and promoted a program on bicycle safety and use of helmets.
- Declared cheerleading a sport and joined with the Ken-

tucky High School Athletic Association to require cheerleader coaches to meet continuing sports medicine education and be qualified in CPR.
- Developed and mailed to every member a legislative handbook and distributed the "1990 KMA Legislative Report," an extensive summary of health and medical legislation adopted by the 1990 General Assembly.
- Continued to increase membership to an all-time high in 1990.

Outreach Programs/Committees

The Board of Trustees continued its goal to be an inclusive organization by developing and appointing committees for:
- Foreign Medical Graduates
- Faculty Physicians
- Hospital Medical Staffs
- Interspecialty Council
- Impaired Physicians
- Young Physicians
- Medical Students
- Resident Physicians
- House Staff Orientation (2)
- Freshman Medical School Student Orientation (2)
- 31 standing/6 ad hoc committees involving over 500 members

In August the Board of Trustees honored Hoyt D. Gardner, MD. Doctor Gardner is highly respected throughout the United States and is one of only a few Kentucky physicians ever elected to the office of President of AMA.

In June 1990 staff said goodbye to three staff members. Fay Miles, who served KMA and KEMPAC for 31½ years, and Eileen Dougherty, Manager of the Rural Kentucky Medical Scholarship Fund, both retired. We welcome Vicki Thorpe, who will be working full time staffing KEMPAC and RKMSF. Billy Mabry, who served as staff attorney, resigned in order to return to private law practice. Our staff this past year totaled 283 years of service to KMA, an overall average of approximately 12 years service, with five employees having been with us more than 20 years. That constitutes a lot of experience in addition to years of dedication.

President Nelson B. Rue, Jr, MD, completed an outstanding year, and we attribute many of our accomplishments to his "hands-on" leadership. Doctor and Mrs Rue were truly ambassadors for KMA, and staff will fondly remember them for their kindness and personal interest.

In 1990 S. Randolph Scheen, MD, Secretary-Treasurer, completed 24 years of service to the Board of Trustees. Much of KMA's progress and the transformation from a small association to one of the most effective medical organizations in the country can be attributed to Doctor Scheen's leadership.

Finally, it is appropriate to recognize William B. Monnig, MD, who completed his third term as Chairman of the Board. Doctor Monnig has been a very fair and effective Board Chairman and made significant contributions to the Association. His candid opinions and ability to articulate practicing physician views, particularly during the Legislative Session, made him an invaluable component within leadership.

While 1989-90 signifies a changing of the guard for leadership and staff, we are optimistic about the future and eagerly look forward to working with Preston P. Nunnelley, MD. Doctor Nunnelley is an excellent leader, and his experience will serve the Association well during the coming year.

On behalf of staff, we commend the House of Delegates and the entire membership for their efforts this year and thank each of you for the trust and confidence placed in us.

Robert G. Cox
Executive Vice President

Report of KMA Physicians Services, Inc

KMA Physicians Services, Inc, a holding company, is KMA's only wholly owned subsidiary, and the KMA Building Corporation is the sole subsidiary of KMA Physicians Services, Inc.

The only role of the Building Corporation is to collect rent and to pay mortgage, taxes, insurance, and other maintenance costs of the most recent addition to the Headquarters Office Building. That addition is now over six years old. During the past fiscal year, the Building Corporation operated on a budget with income of $129,336, and expenses of $124,080. It is anticipated to be an approximate breakeven operation until 1997 when the Economic Development Revenue Bond will be paid in full. Current expenses for that Bond are approximately $75,000 annually. Detailed budget and financial statements are being provided to Reference Committee No. 1.

The Building Corporation and KMA Physicians Services, Inc, exist only for specific transactions of the Association as mentioned above which are of a routine nature. We have no adverse matters to report, nor do we anticipate any in the future.

William B. Monnig, MD
Chairman

Report of the Kentucky Medical Insurance Company

There are 6,451 physicians currently enrolled by the Kentucky Board of Medical Licensure. Sixty-three percent of those have entered practice within the last 15 years. This represents a changing world in which new physicians make up a significant majority of Kentucky's practicing physicians. While KMIC's successful service to Kentucky physicians in the past

decade is a matter of record, these physicians quite properly are concerned with today's medical environment, and tomorrow's.

KMIC has played a major role in stabilization and maintenance of the medical liability insurance market in Kentucky, and that role is just as important now as it has been since the company's beginning. KMIC understands the fiscal pressures under which today's physicians operate, and is devoted not only to the concept of service to our physician policyholders, but also to the principle that premium rates shall be kept as low as allowed by our twin goals of reliability and value. We want to serve our physicians today, and be strong tomorrow when our help with claims will be needed.

Many new initiatives are underway at KMIC:

- Our full-time Medical Director, Walter Hume, MD, has taken on his role of representing Kentucky physicians with great enthusiasm. Currently he is recruiting a physician Advisory Committee from all medical specialties throughout Kentucky. This Advisory Committee will have a direct influence on KMIC's programs and services for physicians. Doctor Hume will be visiting and talking with each one of you who takes the time to participate.
- Our executive director of marketing operations, Dave Schweitzer, has put each of our marketing professionals on the road — to meet with you, your office manager, and staff; deliver your policy; answer your questions; and resolve your insurance problems.
- Our manager of risk management and claims prevention, Randolph Starks, has developed new, sophisticated risk management programs and techniques. The combined efforts of KMIC and its policyholders continue to influence the improving claims climate which, in turn, results in lower rates.
- Our Claims Review Committee is comprised of volunteer Kentucky physicians who meet in long, difficult sessions and assist our claims representatives and our expert defense attorneys in maintaining our strong winning case ratio of 83% or more. Kentucky physicians from throughout the state volunteer to serve on our Underwriting Committee, which meets regularly in all-day sessions to help evaluate physicians' claims performance. This is peer review of the highest order.
- Our Board of Directors continues to find ways to improve the quality of our product and to lower its cost. Our Experience Credit for good claims experience has been increased from 5% to 10%, effective July 1, 1990. Our Physicians Experience Pool (PEP) credit of 12% will continue during 1990 and, depending on this past year's experience, this credit should be available in 1991. Retirement benefits such as annually renewable tail coverage limits and free tail coverage after three years of continuous coverage are permanent features of our quality product.
- Our staff and our Board continue to work and meet with the KMA Board of Trustees. The joint committee of the two Boards acted to recommend the election of Russell Travis, MD, Lexington, to the KMIC Board. Doctor Travis was elected to fill the vacancy caused by the retirement of Carl Cooper, Jr, MD, Bedford.

Whether or not you lived through the malpractice insurance crisis of the '70s, KMIC is here to serve you now. We have a quality product, superior service, and a price that is set at a reasonable, responsible rate. We are proud of our financial standing and our defense record. We are proud that KMIC is *your* company.

Ballard W. Cassady, MD
Chairman, Board of Directors

END OF CONSENT CALENDAR ITEMS

Report of the President

The 139th year of the Kentucky Medical Association, 1989-90, was busy and challenging, as predicted. Perhaps our greatest challenge was in the legislative arena. Of the 31 issues the 1989 KMA House of Delegates mandated, 31 resolutions were introduced, and 18 passed. Full details of legislative activities are covered in the report of the Committee on State Legislative Activities. We were fortunate to have many supportive legislators and to have passed several bills favorable to Kentucky physicians.

The health agenda was dominated by the Certificate of Need (CON) controversy granting Jefferson County hospitals exemption from CON. On a more positive note, important health legislation relating to indigent care, AIDS, Living Will, and protection of retirement plans from judgment was approved by the 1990 Kentucky General Assembly.

During the Session, KMA closely monitored over 225 bills which directly or indirectly affected the practice of medicine. We had a very successful Session which had as its roots strong cooperation among members, the Board of Trustees, and staff.

We feel that the 11 Wednesday evening meetings KMA's Quick Action and Legislative Activities Committees held in Frankford with our lobbying staff were very productive. In addition, KMA officers were called upon to testify before several legislative committees. We feel that testimony before the House Committee hearing regarding proposed legislation on "Nurse Practitioners' Right to Prescribe" was influential in defeating this proposal.

The Legislative Seminar held by KMA in Frankfort at the beginning of the Session of the General Assembly was very helpful, with legislative leadership speaking to our group about their issue positions. I am even more convinced now than when I took office last September that the legislative arenas, state *and* federal, are our most vital battlegrounds.

In addition to the weekly Frankfort meetings during the

Session, I have traveled to KMA Headquarters in Louisville for numerous meetings, as well as to Health Care Access Foundation meetings in Lexington. In December 1989, we attended the AMA Interim Meeting in Honolulu, Hawaii, and in February 1990, the AMA National Leadership Conference and Communication Skills Workshop in Phoenix, Arizona.

In June I participated in the Kentucky Bar Association's Annual Meeting in Lexington, addressing the ethical issues in medicine today. Later that month, I attended the AMA Annual Meeting of the House of Delegates in Chicago, where each state President was recognized. Every effort has been made to represent the interests of Kentucky physicians and to contribute to these sessions and to the Resolutions adopted. Your AMA Delegates worked diligently for you, as did KMA staff and other officers.

It was my personal pleasure to address the Annual Meeting of the Auxiliary to KMA in Owensboro in May. The fine auxilians in Kentucky helped make possible a record-breaking gift of more than $2 million to AMA-ERF this year. The Auxiliary is a vital part of our work for the causes of organized medicine.

I have participated as well in KYCANS — the Kentucky Coalition to Address the Nursing Shortage, the organizational meetings of the Committee for Health Education in the Public Schools (a cause I heartily support), and the Coalition to Address Teenage Pregnancy in Kentucky.

I have attended Trustee District meetings across the state — Fayette County, Pikeville, Ashland, Kenton County, Elizabethtown, Paducah, Richmond, and Bowling Green. I cannot emphasize too strongly the value of meeting in a cordial, informal setting with our legislators at these Trustee District dinners. The legislators gladly speak and answer questions in these groups, and valuable rapport is established.

One of the greatest pleasures of the office of President is attending the annual meetings of adjacent states' associations. We have attended two Ohio meetings — 1989 in Dayton and 1990 in Cleveland. We have also attended the Indiana meeting in Indianapolis; the Virginia meeting in Richmond; the Illinois meeting in Chicago; and, just last month, the West Virginia meeting in White Sulphur Springs. In addition to enjoying warm hospitality and making good new friends, there is a widened perspective gained from the exchange of ideas.

The problem of indigent care continues to grow, in spite of increased Medicaid reimbursement for physicians and expanded services. The Kentucky Physicians Care program was fortunate this year to reach an agreement with Pfizer Laboratories to use its entire line of products at no cost for one year for patients eligible for KPC. At the AMA Annual Meeting in Chicago in June, Lt Governor Brereton C. Jones received the AMA's "Distinguished Service by a Layman" award for his participation in this program.

The problem of access to health care by the indigent is going to escalate, unfortunately, as more and more Americans are living in poverty. Of equal concern is the lack of affordable health insurance for many working Americans. Whereas, wages and job security have been the focus of workers' concerns, this year health care has pushed those aside.

According to Lane Kirkland, President of the national AFL-CIO, it is the single "most pressing challenge in the workplace." Kirkland has declared that the federation, which represents 14.1 million workers, will press its campaign for adequate coverage of working families at affordable cost "for the rest of 1990 and as far into the future as it takes to get a solution through Congress." This will include a $3 million media blitz which will affect us all.

Of great interest to physicians this year has been the implementation of 1986 federal legislation creating a National Practitioner Data Bank, a repository of information on professional conduct and malpractice awards. The potential for inappropriate data retention and abuse of the information is, of course, of concern.

On an optimistic note, I am pleased to announce that membership in KMA continues to grow and at the end of 1989 had reached an all-time high of 5,460 physician, resident, and medical student members. During the last decade, active membership has increased 18%, and the total KMA membership grew 36% during this period. Student and resident membership flourished during the 1980s, with a 74% increase in student members and a *230%* increase in the In-Training category. This is particularly encouraging since it indicates an awareness and a willingness of young physicians to participate in the future of medicine in Kentucky.

Although a "Decade of Decision," full of challenges and change had been predicted, I am sure none of us expected the developments on the international scene. Within this past year, we have seen the Berlin Wall torn down, a reunited East and West Germany, and the US and USSR allies for the first time since the 1940s.

Just as the tensions of the Cold War faded, the crisis in the Middle East erupted. Thousands of American military personnel, including many physicians and allied health care personnel called from Reserve status, are in battle-ready positions in Saudi Arabia. The need for additional billions for defense spending will likely cause an Administration and Congress, not sympathetic to the concerns of organized medicine, to further cut the health care budget. How this will play in the face of the public outcry for change has yet to unfold.

In my final report, I want to express my appreciation, along with Sue's, to the membership, the Board of Trustees, and KMA staff for your confidence in electing me to this office and for your support during my term as your President. It has been an honor to serve, for I love this profession and shall always have "Pride in Medicine."

Nelson B. Rue, MD
President

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed the Report of the President. The Committee wishes to acknowledge the long hours and exemplary leadership that Doctor Nelson Rue has demonstrated throughout his term.

Reference Committee No. 1 recommends that the Report of the President be filed.

Report of the President, Auxiliary

The enthusiastic spirit of the members of the Auxiliary to the Kentucky Medical Association has been captured during this 1989-90 year to make a difference in the lives of the people of our state.

Kentucky's auxilians worked as a team to enhance the quality of health care in their communities. They were ambassadors of good will for the medical community and keen perceivers of important community health needs. Projects targeted the poor, the homeless, newcomers, the aging, expectant parents, infants, school age children, and adolescents. As well, general awareness efforts concerning seat belt safety, AIDS education, and earthquake preparedness were initiated. For the first time, county auxiliaries and auxilians were recognized at our annual convention for their role in facilitating projects which met significant community health needs.

The issue of teenage pregnancy in Kentucky was addressed through the initiation of a coalition with the Kentucky State Cabinet for Human Resources for the eventual distribution of ACOG materials to every school district in our state. Also, to ensure that auxilians were properly informed on the AIDS issue in Kentucky, a workshop on this important health concern was offered at Fall Board '89.

Although education was the "hot" topic of Kentucky's legislative session this year, more than 200 bills focused on health concerns. Legislative workshops, briefings, and seminars, sponsored by the Auxiliary and the KMA, were held during the year, culminating in a legislative hands-on "Day at the Capital."

Kentucky's priceless medical museum, McDowell House, an Auxiliary project for more than 40 years, received national attention in *FACETS*. This led to a gift from the Auxiliary to the Georgia Medical Society of historical papers documenting our Auxiliary's early efforts to recognize the contributions of Jane Todd Crawford and Doctor Ephraim McDowell to medical history.

Kentucky has had a good year — our AMA-ERF efforts have exceeded all previous efforts by 22%, by raising over $63,000.00. This year, efforts were begun to work with KMA in raising these monies which benefit medical education, through a joint holiday sharing card sent to legislators residing in districts of Board members.

Nationally, AKMA was recognized at the 1990 AMAA House of Delegates with the following awards:

- Largest per capita AMA-ERF contribution in the nation — to Boyd County — $243.26 per capita.
- 2nd largest state per capita AMA-ERF contribution in the nation — to Kentucky — $53.34 per capita.
- 5th greatest AMA-ERF contribution in the nation — to Boyd County — $17,515.00 raised.

Regional meetings have been reinstituted in an attempt to reach out to our members, with a special effort to reach potential members-at-large in unorganized counties. We are trying new ways to recruit and retain our membership. We have made a concerted attempt to extend membership to medical student and resident physician spouses — our Auxiliary leaders of tomorrow. For these efforts, Kentucky received recognition at the 1990 AMAA House of Delegates meeting as the state with the greatest increase in resident physician/medical student spouse membership!

At the 1990 KMA House of Delegates meeting, organizational business was transacted and a new committee dealing with medical heritage was established. At this meeting, as well, AKMA endorsed the mission statement of the Kentucky Coalition on Availability of Nurses "to promote the availability of an optimal supply of nurses to meet the health care needs of citizens throughout the Commonwealth of Kentucky." This follows action by the KMA and numerous other Kentucky organizations concerned about the future of quality health care in Kentucky. And, we welcomed a donation from KMIC to the AKMA Health Career Fund — a fund which provides scholarship assistance to needy students.

Doctor's Day was celebrated this year in many different ways in each of our counties. On a statewide basis, we initiated an essay contest for high school students, asking them to address the issue,"How I View Medical Care in the Year 2000." Through this process, students had the opportunity to investigate and expand their awareness of the many changes going on in medicine today. The winner of the essay contest was Michael Calhoun of Madisonville High School, with second place captured by Kevin Speaks of Somerset High School.

We have tried to enhance our connection to one another and to those around us, as together we have tried to make a difference in the quality of life in our state. We realize that all of these efforts pose an even greater challenge, for these accomplishments are merely steps along the path to greater successes in the future.

Esther Jansing
AKMA President
1989-90

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed the Report of the President, Auxiliary. Mrs Jansing's service to the Auxiliary is greatly appreciated. Reference Committee No. 1 recommends that the Report of the President, Auxiliary be filed.

Report of the Chairman, Board of Trustees

With this report, I conclude my tenure as a Trustee and as your Board Chairman. To have served as Chairman of the Board of Trustees for three years has been a challenging, enlightening, and humbling experience. I have gained a unique insight into the role organized medicine plays in the daily lives of physicians, our families, and our patients. I have witnessed firsthand how KMA represents us before government, third parties, allied groups, media, hospitals, legislators and Congressmen, business, the public — and indeed with every element of our professional environment.

I have observed the dedication and commitment of our colleagues to maintain the highest standards of the profession by their service on committees, councils, the Board of Trustees, and the House of Delegates. I wish every Kentucky physician could have the opportunity to see their professional organization operate from this seat. If that could come true, I think we would be the proudest, most unified, most productive organization to have ever existed. Thank you for letting me serve as your Chairman.

Much was accomplished this year. We had a successful Kentucky General Assembly, as was reported to you in a special report sent to all members and in our final reports to the House of Delegates. State Legislative Chairman Wally Montgomery, MD, deserves special recognition for the inordinate amount of time he gave for KMA's cause, for his expertise, and for his total commitment to our legislative program.

The Quick Action Committee met for 3-4 hours in Frankfort every Wednesday night for three months to consider our official position on hundreds of bills, and to provide general guidance to medicine's overall efforts. Staff was superb and our results were meaningful. On June 28, we lost a great colleague and champion of our cause in the Kentucky Senate. Senator Jack Trevey, MD, died suddenly on June 28, 1990, at the age of 57. Many of our members will never know of his strengths or how hard he fought for the profession that instilled such pride in him. I did, and he will be greatly missed.

During the year, we dealt with many other issues such as Medicare and Medicaid, health care access, and care for the indigent. Managed care systems had our attention, as did professional liability insurance, AIDS, continuing medical education, and PROs. National legislative matters were more intense, impaired physicians received help, and we conducted our 20th and final three-day Emergency Medical Care Seminar. The list goes on and on, and I hope you will read the many committee reports that summarize KMA's activities.

Lt Governor Brereton Jones was presented with the Outstanding Layman Award by the American Medical Association at its Annual Meeting in Chicago in June for his role in the Kentucky Physicians Care Program and the Kentucky Health Care Access Foundation. We had a large KMA delegation in attendance, and were proud to see the Lt Governor receive this recognition.

A report on the Legal Trust Fund is included annually in the Chairman's Report. Expenditures were made during the past year of $5,359.61, and the Fund's balance is $187,808.76.

The Kentucky Medical Association is a superb organization and a strong force working on our behalf to permit us to provide that care which we feel is in our patients' best interest. KMA works for us every day to maintain a degree of independence that few others in our society enjoy. I again want to pay tribute to the members of the Board, the committee members, delegates, and the entire membership for your efforts this past year, and for your support.

The following summary of Board meetings is submitted to assist you in assessing the scope of your Board's activities. Complete Minutes of all Board meetings will be provided to Reference Committee No. 1.

SUMMARY OF BOARD MEETINGS

First Meeting, September 21, 1989

Acting as temporary Chairman, KMA Secretary-Treasurer S. Randolph Scheen, MD, introduced the newly elected members of the Board and the new officers: Preston P. Nunnelley, MD, Lexington, President-Elect; John D. Noonan, MD, Paducah, Vice President; Danny M. Clark, MD, Somerset, Speaker, House of Delegates; C. Kenneth Peters, MD, Jeffersontown, Vice Speaker; Robert P. Meriwether, MD, Paducah, Trustee, First District; William L. Miller, MD, Greenville, Trustee, Third District; Russell L. Travis, MD, Lexington, Trustee, Tenth District; Harold L. Bushey, MD, Barbourville, Delegate to AMA (effective January 1, 1990); and Larry C. Franks, MD, Paducah, Alternate Delegate to AMA (effective January 1, 1990).

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1989-90 KMA year. William B. Monnig, MD, Edgewood, was reelected Chairman of the Board, and Emanuel H. Rader, MD, Pineville, was elected Vice Chairman. Cecil D. Martin, MD, Carrollton, and Lucian Y. Moreman, II, MD, Elizabethtown, were named as Trustees-at-large.

It was noted that the KMA Executive Committee members also serve as the Board of Directors of KMA Physicians Services, Inc (KMA's holding company). The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the following year.

The Board members also made several appointments to the KEMPAC Board of Directors, and approved the merger of the Campbell-Kenton County Medical Society with the Boone County Medical Society to create the Northern Kentucky Medical Association, Inc. It was announced that October 1, 1989,

had been designated "Doctor Carl Cooper Day" in Bedford, and that Board members were invited to attend a reception honoring Doctor Cooper.

The Board voted to hold the 1990 Annual Meeting on September 24-27 at the Hyatt Regency Hotel and Commonwealth Convention Center in downtown Louisville.

Second Meeting, December 13-14, 1989

The KMA Board of Trustees held its second meeting of the Associational year on December 13-14, 1989, at the KMA Headquarters Office in Louisville.

Nelson B. Rue, MD, reported on his activities since becoming President of KMA in September, to include attending meetings of the AMA, the KMA, Trustee District meetings, and the newly formed Kentucky Coalition on the Availability of Nurses.

Reports were also presented by the AKMA President; KMA Secretary-Treasurer; Senior Delegate to AMA; President of the Board of Medical Licensure; Vice Chairman, KMIC Board of Directors; Dean, University of Louisville School of Medicine; and Commissioner, Bureau for Health Services.

It was noted that KMA membership stood at an all-time high of 5,460 in its combined membership categories, with 4,163 dues-paying members. Legal Counsel reported that KMA had been permitted to file an amicus curiae brief in a court case involving extraordinary means of treatment of terminally ill patients.

The Chairman reported that as a result of the Report of the 1988-89 President, an Ad Hoc Committee on Advocacy Systems had been appointed. He also appointed three KMA Board members to serve with two physicians named by KMIC to the Ad Hoc Committee for the KMIC Board Election Process.

Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, discussed in great length KMA's legislative plans for the 1990 Kentucky General Assembly; and Donald C. Barton, MD, Chairman of the Committee on National Legislative Activities, reported that the issue of most concern to medicine during the recent Congress dealt with changes to the Medicare law.

The Board voted to approve renewal of the Blue Cross and Blue Shield health insurance program for members as recommended by the Committee on Medical Insurance and Prepayment Plans. It was reported that the Ephraim McDowell Cambus-Kenneth Foundation, now a legal entity, is in a position to accept ownership of a farm in Danville, Kentucky, once owned by Doctor Ephraim McDowell, upon the deaths of the current owners.

Larry P. Griffin, MD, Chairman of the Continuing Medical Education Committee, reported that KMA had received notification from the Accreditation Council on Continuing Medical Education that the Committee is functioning effectively. Russell L. Travis, MD, Chairman of the Kentucky Physicians Care Operating Committee, reported that since the inception of the Kentucky Physicians Care Program, 65,387 calls had been placed to the KPC hotline, and 30,255 referrals had been made. Doctor Travis noted that meetings have been held with representatives of pharmaceutical companies in an attempt to secure drugs for KPC patients, and that it appeared some help would be forthcoming.

The Board selected names for submission to the Governor for the Advisory Council on Athletic Trainers, and the Board of Licensure for Nursing Home Administrators. It also granted permission to lend the Association's name as a cosponsor of a Kentucky Bar Association seminar on substance abuse, and to participate on a KBA program dealing with medical ethics, the law, and new technology.

Third Meeting, April 18-19, 1990

The KMA Board of Trustees met on April 18-19, 1990, at the KMA Headquarters Office in Louisville.

The Board members heard reports from the President; the President of the Auxiliary to KMA; the Senior Delegate to AMA; the President of the Board of Medical Licensure; the Dean of the University of Kentucky; the Vice Chairman of the Board of KMIC; and the Commissioner of the Bureau for Health Services.

Secretary-Treasurer S. Randolph Scheen, MD, reported that the Active Membership category had increased by 74 members since last April. The Board adopted a special Resolution to commend Fay Miles for her nearly 30 years of service to KEMPAC and KMA, to be presented at a staff retirement luncheon.

Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, reported in detail on the recently completed Kentucky General Assembly. Doctor Montgomery presented a slide presentation which highlighted 229 bills, of 1,800 introduced, that KMA had monitored throughout the Session. Recent developments regarding attempts by nurse practitioners to prescribe were also discussed.

Russell L. Travis, MD, Chairman of the KPC Operating Committee, reported that negotiations are underway with a major drug company to obtain 100 percent of its product line for the KPC program. The Board directed the Committee on Constitution and Bylaws to present proposed changes in the Bylaws pertaining to Life Members to the House of Delegates, and approved payment of expenses for directors of impaired physicians programs in other states to meet with the KMA Committee on Impaired Physicians.

The Board members adopted a budget for the 1990-91 Association year, approved a slate of directors to be elected to the KMIC Board, and approved changes to the KMIC Articles of Incorporation. Legal Counsel presented an update on two lawsuits of interest to KMA, including one in which an amicus curiae brief had been filed on behalf of the Association.

The application of the Kentucky Geriatrics Society for specialty group recognition was approved, and it was voted to submit the name of Ardis D. Hoven, MD, Lexington, to the AMA for consideration of appointment to its Women in Medicine Advisory Panel. The Board then selected names for submission to the Governor for the Kentucky Board of Medical Licensure and the Nurse Practice Council.

The Committee on Medical Insurance and Prepayment Plans asked the Board to consider submitting a Resolution to the AMA House of Delegates resolving that AMA introduce amendments to PL 93-406 requiring self-insurance health care plans to be subject to the authority of state insurance regulations. The Board approved submission of the Resolution to the AMA, and also asked staff to investigate the complaint of a member regarding Worker's Compensation.

Fourth Meeting, August 8-9, 1990

The KMA Board of Trustees held its fourth meeting of the Association year on August 8-9, 1990. Reports were given by the President; Auxiliary President; Secretary-Treasurer; Commissioner for Health Services; Dean, U of L School of Medicine; and representatives of the Kentucky Medical Insurance Company. The Senior Delegate to AMA highlighted actions taken at the AMA Annual Meeting in June, and the President of the Kentucky Board of Medical Licensure summarized activities of the BML during the past year.

A special presentation was made to Hoyt D. Gardner, MD, Louisville, in appreciation for his dedication to organized medicine. He was presented with a portrait of himself which will hang in the KMA Headquarters Office.

Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities (COSLA), reported that each KMA member had received the "1990 KMA Legislative Report," a summary of action by the 1990 Kentucky General Assembly. The Board adopted several recommendations of the COSLA relating to Certificate of Need for referral to the 1990 House of Delegates.

It was noted that legal counsel had been asked to prepare an analysis of a new Blue Cross and Blue Shield HMO/PPO contract, and that the PRO Advisory Committee had investigated several incidents involving Sentinel Medical Review. The Board members received a copy of "A Syllabus of Sports Injury Care for the Kentucky High School Coach," and approved the use of KMA's name as a cosponsor of a Board of Education program on drug awareness.

The Board appointed Jannice O. Aaron, MD, Louisville, to the *Journal* Editorial Board to fill the vacancy created by the death of David L. Stewart, MD, Louisville, and submitted the name of Donald C. Barton, MD, Corbin, to the Health Care Access Foundation for appointment to an additional four-year term.

Endorsement was given to a "Patient's Bill of Rights," formulated by the Ad Hoc Committee on Quality of Care, and to the AMA's "Health Access America" program, and both were forwarded to the House of Delegates via committee reports.

The Board authorized a $10 voluntary billing for the Legal Trust Fund for 1991, and approved payment from the Fund for two lawsuits in which KMA has filed amicus curiae briefs. It also approved an increase in subscription rates to the *Journal of the Kentucky Medical Association.*

The ad hoc committee reports of the Board were finalized, and a review was made of each final report submitted by the KMA committees. A list of actions taken by the 1989 House of Delegates was distributed for review of the implementation of each action, and it was noted that the same information would be sent to every Delegate as an addendum to the Board Chairman's Report to the 1990 House. The Board also approved several Resolutions for introduction into the House.

The next meeting of the Board was scheduled for Sunday, September 23, 1990.

Executive Committee

The guiding hand for the day-to-day operations of the Association between meetings of the full Board is the eight Officers and Trustees who comprise the Executive Committee. Four of those eight serve as the Quick Action Committee, and are the President, President-Elect, Chairman of the Board, and Secretary-Treasurer. These four make policy decisions when needed on a spur-of-the-moment basis, and when an agenda is not sufficient to call in the full Executive Committee.

It is difficult to adequately recognize these individuals for their time, expertise, dedication, and contributions to the medical profession in Kentucky. The Executive Committee generally meets prior to Board meetings and considers major decision items in considerable detail to propose recommendations to the full Board. This year, they met eight times. They review the full scope of KMA activities and consider issues in depth.

The Quick Action Committee met 15 times this year, and most of those sessions were during the Kentucky General Assembly. During the Legislative Session, the Quick Action Committee, Legislative Chairman, and other invited guests meet weekly to guide KMA's legislative agenda.

Sessions are held with allied groups and governmental bodies as we work our way through the three and one-half month KGA. Each physician member not only performed willingly, but with enthusiasm and untiring efforts. Most meetings lasted until 9:00 or 10:00 PM. Special gratitude goes to these officers, and a very special salute is again sent to Wally Montgomery, MD, our State Legislative Chairman, who worked *daily* on our legislative program, and was in Frankfort many times to testify on our behalf.

Ad Hoc Committees

The seven ad hoc committees of the Board working this year were those on: (1) the Study of Advocacy Programs; (2) Professional Liability Insurance; (3) Quality of Care; (4) Indigent Care; (5) Foreign Medical Graduates; (6) Headquarters Office Building; and (7) Nomination of KMIC Board Members.

Detailed reports of the Ad Hoc Committees on Advocacy Programs, Professional Liability Insurance, and Quality of Care are a part of this report, although some are referred to other Reference Committees.

The Ad Hoc Committee on PLI continues to provide a valuable service by overseeing our PLI campaign. It will continue to be busy during the coming year preparing for the 1992 session of the Kentucky General Assembly.

The Ad Hoc Committee on the Headquarters Office has been meeting this year because of a rather urgent need for additional office space for KMA and KMIC. It is the contention of both Boards that the staffs of KMA and KMIC should remain housed together. We are presently in critical need of 10,000 to 15,000 additional square feet, and are considering various options, including expansion at our present location or moving to a larger building elsewhere. No final decision is expected before the Annual Meeting.

The KMIC Board Election Nominating Committee, chaired by Cecil D. Martin, MD, submitted its nominees for KMIC Board positions at the April Board meeting. Russell L. Travis, MD, Lexington, was elected as a new member of the KMIC Board, and recognition was given to Carl Cooper, Jr, MD, Bedford, who retired from the Board.

The Ad Hoc Committees on the Study of Advocacy Programs, Quality of Care, Indigent Care, and FMGs have completed their assignments, and will probably be discharged with our gratitude, recognizing they can be reappointed as needed.

One final highlight I have not mentioned, but you will find in the Report of the Cambus-Kenneth Foundation (No. 44), is the gift of the Cambus-Kenneth Farm by Mr and Mrs Joe Wallace to the Foundation, which will receive it upon their deaths. The final papers regarding this agreement were signed this year, and we are most appreciative of the Wallaces' generosity, and have conveyed KMA's commitment to the preservation of this farm.

It has been my privilege to work with the staff of the Kentucky Medical Association for the past three years as Chairman of the Board of Trustees. It is impossible to adequately recognize the high quality of work our staff performs. Under the direction of Bob Cox and his senior staff — Bill Applegate, Bob Klinglesmith, Don Chasteen, Lillie Byrd, and Donna McMahel — and the various support staff members, the Association is served continuously, courteously, and professionally. The staff members are recognized as indispensable by your medical leadership, and are recognized throughout the country by their peers as some of the best in their field. At home, however, we rarely demonstrate our appreciation for their dedication and expertise.

I fully realize that these comments in an annual report are inadequate to express the Board's sentiments, but wish to extend our heartfelt gratitude.

I would also like to thank Debby Traughber for her help in keeping me organized, preparing the proceedings of the Board, and supplying me with all appropriate background information that has allowed me to preside over the meetings of the Board and the Executive Committee of the Board.

As I close my third and final report as Chairman of the Board of Trustees, I again want to deeply thank the Board and committee members, each and every KMA staff member, and my colleagues from across the state for the strong and continuing support I have received.

We must continue to stand side by side as we look to the future and maintain our pride in medicine.

William B. Monnig, MD
Chairman

Report of the Ad Hoc Committee to Study Advocacy Programs

Addendum to the Report of the Chairman, Board of Trustees

The KMA Ad Hoc Committee to Study Advocacy Programs, at its first meeting, adopted the following mission statement:

> The Ad Hoc Committee to Study Advocacy Programs shall review and analyze various issues relating to the economic representation of physicians in Kentucky. Also, the Committee shall explore the legal and economic limitations of organizing a statewide physician-sponsored alternate delivery system in Kentucky. This shall include a review of antitrust restraints on collective bargaining and the formation of PPOs; the ability of physicians to be represented by a collective bargaining group; and collective bargaining activities which the Kentucky Medical Association could pursue.

The Committee met on December 6, 1989, and on June 7, 1990. The Committee explored the options which KMA has in terms of serving as a collective bargaining agent for Kentucky physicians. This was done with recognition that any such action would have to be conducted in a manner not to violate the Sherman Antitrust Act and other free-trade laws. There is a "labor exemption" to the antitrust laws for collective bargaining as authorized by federal labor laws. The Labor Board has recognized that *employed* physicians may self-organize for the purpose of improving their terms and conditions of employment through collective bargaining.

However, very few physicians would meet the definition of *employed* as defined via labor laws.

It was noted that KMA is currently providing many services that are provided by labor unions for their members. This is being done, of course, without any violation of any antitrust legislation.

The second alternative which the Committee explored was the possibility of organizing a statewide PPO or IPA as an arm of the Kentucky Medical Association. After discussion with legal counsel, it was determined that such proposals have more problems associated with them than benefits. Under the current laws and economic climate, it would be nearly impossible for KMA to enter into this form of arrangement.

I would like to take this opportunity to thank the members of the Ad Hoc Committee to Study Advocacy Programs for their work and dedication during this Associational year.

It is recommended that this Committee be abolished, but the Board be charged with the thought of reinstituting this Committee at a point in time when the legal and economic climates change to a degree that would warrant addressing this area.

Bob M. DeWeese, MD
Chairman

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed the Report of the Chairman, Board of Trustees, along with the Report of the Ad Hoc Committee to Study Advocacy Programs. Reference Committee No. 1 wishes to commend Doctor Monnig for his great stamina in serving three terms as Chairman of this august Board.

Reference Committee No. 1 recommends that the Report of the Chairman, Board of Trustees, be filed, and that the Report of the Ad Hoc Committee to Study Advocacy Programs be adopted.

Report of the Secretary-Treasurer

It is with both pleasure and some sadness that I tender my report to you this year as Secretary-Treasurer. This will constitute the 24th report I will submit in my years of service, and the final one.

It is impossible for me to adequately express my feelings to the Delegates, the membership, and the Board of Trustees, as I reach this milestone. My years of service have paralleled my own medical career, and the two combine to make up my professional life, and a good bit of my personal life, as well.

The hours that I have had the privilege to spend with the medical leaders of this state and others are literally countless. I have witnessed the resolution of seemingly insoluble dilemmas, as well as the transformation of innocuous matters into momentous ones. In a word, I have witnessed and lived over two decades of the evolution of medicine from the vantage point of my office and my service to this Association. It has been a most rewarding experience.

Once again, I am pleased to report that our Association is fiscally sound. I would direct your attention to the Report of the Auditor and would urge any questions or comments you might have to the auditors, to myself, or any member of the Board of Trustees. No dues increase is anticipated, and we will gratefully terminate this year in a sound position. I would also urge your attention to the reports of the Board and committees contained in this booklet and hope you can appreciate the many hours and efforts that went into the work these reports represent. KMA's committee structure is truly the backbone of the organization.

Our physical facility is in good repair, yet barely adequate for all the activities KMA undertakes. To this end, attention is now being directed to expansion of the building, with the future possibility of assuming land that may become available because of changes in I-264, the Watterson Expressway, which abuts the KMA property. Further information on this issue is contained elsewhere in these reports.

A number of major efforts are underway which are worthy of highlighting. These include the commendable efforts of our Committee on State Legislative Activities, our nationally recognized Kentucky Physicians Care program, our intensified continuing medical education activities, and the work of our Impaired Physicians Committee, to name only a few.

It is extremely gratifying to me, in looking back through my years as Secretary-Treasurer, to see how far we have come and developed as a profession and an association. To express my gratitude to individuals would be impossible. I have yet to come in contact with any individual in my Association work from whom I have not received some benefit. Your faith in my duties and service is humbling, and I will end by simply saying, "thank you."

S. Randolph Scheen, MD
Secretary-Treasurer

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed the Report of the Secretary-Treasurer, and would like to go on record in expressing our appreciation for Doctor Randy Scheen's untiring dedication to this position for the past 23 years.

Reference Committee No. 1 recommends that the Report of the Secretary-Treasurer be filed.

Report of the Kentucky Physicians Care Operating Committee

As this report is being written, the Kentucky Physicians

Care program is starting its 66th month of operation. During that time, 73,444 individuals have been certified eligible for the program and 32,280 referrals have been made, which we estimate resulted in over 129,000 physician encounters. This latter figure is estimated because, in most cases, once a patient is seen by a participating physician, he or she tends to continue seeing that physician and, as a result, does not continue to call the toll free number.

The Headquarters Office continues to receive telephone inquiries and requests for referral. Over 71,150 calls have been made to the toll free number since the program began in January 1985.

The participation and support of the physicians in Kentucky continue to be excellent. Our current level of participating physicians is 2,332, representing a high percentage of the physicians who are actively practicing medicine in Kentucky.

Last year the Committee reported our frustration over the fact that we had been unable to satisfactorily add a pharmaceutical component to the program. Some manufacturers had indigent care programs but they required special certification, individual paperwork, and often entailed long delays while that paperwork was processed. Others offered liberal access to sample pharmaceuticals, but that brought with it problems with storage and resupply. In addition, some items are not available in sample form.

This year I am pleased to report that we have added a pharmaceutical component through the generosity of the Pfizer/Roerig Corporation and the enthusiastic participation of the pharmacists across the state. The Kentucky Pharmacy Providers project began July 16. Participating pharmacists will waive their dispensing fees when Pfizer/Roerig products are dispensed to KPC patients, and Pfizer will replace those products to participating pharmacists free of charge. Pfizer is donating its entire product line for one year.

We believe this is a significant step forward in this plan and very much appreciate the enthusiasm and generosity of Pfizer and participating pharmacists who are both members and nonmembers of the Kentucky Pharmacists Association. As this report is being written in July, 282 pharmacies have agreed to participate, and Pfizer is budgeting in excess of $1 million for the program. We believe this shows a tremendous degree of social sensitivity on the part of Pfizer and are most hopeful that other manufacturers will step forward and participate in a similar manner.

The Committee would particularly like to thank Charles L. Hardwick, Vice President for Civic Information, Pfizer Corporation, and Deborah Smith-Callahan, RN, Government Relations Manager for Pfizer, for the leadership role they took in bringing this project to Pfizer's senior management. Developing and implementing this program was no small undertaking and Mr Hardwick and Ms Smith-Callahan made an extraordinary effort coordinating the many facets of the program through the Pfizer Corporation. In addition, we want to thank the Board and staff of the Kentucky Pharmacists Association for their leadership in bringing Kentucky pharmacists into the program.

The Operating Committee cannot overemphasize its deep appreciation for the ongoing participation and support of the over 1,060 primary care physicians who are the backbone of this program. Primary care physicians remain as the initial contact for the vast majority of referrals. The number of free services rendered by them since this program began is truly remarkable, and we appreciate their efforts on behalf of KPC patients and the medical profession in Kentucky.

The Kentucky Health Care Access Foundation continues as the primary funding source for the program. The Foundation underwrites the cost of the toll free telephone lines, two full-time employees, and a third part-time person hired on an as-needed, temporary basis. According to the Foundation, its financial contribution since the onset of the program through March 31, 1990, totalled $323,875.86.

KMA continues to provide space at the Headquarters Office, telephone equipment, supplies, furniture, computer time and equipment, postage, and KMA staff involvement as needed.

The Cabinet for Human Resources has continued to be extremely cooperative during the course of the project. Karen Doyle and Jim Randall from the Department for Social Insurance continue to work closely with KMA/KPC staff and have given a considerable amount of time and effort to the program, as have the 1,000 field workers in the 120 county CHR offices across the state.

Last year we reported that the Kentucky Physicians Care program had been honored by being named the first recipient of the AMA President's Citation for Service to the Public. This past June, during the AMA Annual Meeting in Chicago, Lieutenant Governor Brereton Jones received the AMA Citation of a Layman for Distinguished Service for his efforts regarding the Kentucky Physicians Care program. The AMA Citation of a Layman for Distinguished Service is presented annually to an individual not of the medical profession who helps achieve the ideals of medicine by cooperation or aid in the advancement of medical science, medical education, or medical care.

Kentucky continues to receive national recognition for this unique program, and Kentucky's medical profession is viewed by its peers as an active, progressive leader in dealing with the issue of indigent care.

Your Chairman was invited to speak to the Annual Meeting of the New Hampshire Medical Society this spring to discuss the Kentucky Physicians Care program, and the Headquarters Office continues to receive many requests for information on the program from other medical associations around the country. The Arkansas Medical Society has implemented a program similar to the KPC program and other states have appointed committees to discuss the feasibility of beginning similar projects.

Last year, the House of Delegates approved the Committee's recommendation that the major participants in the KPC program determine if there was interest in a long-term plan of action to address the needs of the medically indigent. Due to the significant effort necessary to develop and implement the pharmaceutical component of the program, we did not initiate a meeting of those organizations this year. However, we do plan to get such a meeting together next year.

The Committee is pleased to report that the Kentucky General Assembly recognized the efforts of the Kentucky Physicians Care program this year. House Resolution 157 expressed appreciation and thanks to Kentucky physicians and the Kentucky Medical Association for providing medical care to the uninsured through the KPC program.

The Governor's budget proposed an $18 million increase for physician reimbursement under the Kentucky Medical Assistance Program. This increase will reimburse physicians participating in Medicaid at a return of approximately 60% of 1980 profiles. An additional 100,000 Kentuckians will become eligible for Medicaid benefits in fiscal year 1992.

Senate Bill 239, introduced by Senator Bailey, calls for Medicaid reimbursement to physicians to be increased annually, beginning October 1, 1992, in increments which represent a minimum 75% of the most recently reported annual change in the Consumer Price Index as computed by the US Department of Labor. The bill also creates a multiple employer health insurance trust fund in 15 Area Development Districts. It will assess each hospital 0.5% of the hospital's total revenue, to be paid by hospitals on a quarterly basis, the money to be used to receive federal funds on a 72-28 matching basis. The bill would also increase Medicaid payment to family practice physicians in certain underserved areas.

We believe that the Kentucky Physicians Care program played a role in demonstrating the needs of the medically indigent in Kentucky and the fact that the voluntary private sector is working to address those needs.

Therefore, the Committee suggests that KMA continue the Kentucky Physicians Care program through December 31, 1991, contingent on:

1. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985, 1986, 1987, 1988, 1989, and 1990;
2. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;
3. The Kentucky Hospital Association continuing its Fair Share program as currently operated;
4. The Kentucky Health Care Access Foundation continuing to vigorously encourage the active participation of all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share program, as may be appropriate; and
5. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

As Chairman, I am most grateful to the many individuals and organizations that make this most significant program possible.

Russell L. Travis, MD
Chairman

RECOMMENDATIONS:

1. The Committee recommends that KMA continue the Kentucky Physicians Care program through December 31, 1991, contingent on:
   A. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985, 1986, 1987, 1988, 1989, and 1990;
   B. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;
   C. The Kentucky Hospital Association continuing its Fair Share program as currently operated;
   D. The Kentucky Health Care Access Foundation continuing to vigorously encourage the active participation of all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share program, as may be appropriate; and
   E. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed the Report of the Kentucky Physicians Care Operating Committee. The Committee notes recent difficulties in enrollment of physicians for this program, and suggests a recommitment be considered by all Kentucky physicians.

Reference Committee No. 1 recommends that the Report of the Kentucky Physicians Care Operating Committee and its Recommendations be adopted.

Resolution B

Recognition of Pfizer, Inc.
Board of Trustees

WHEREAS, the implementation of an outpatient prescription medication program has been a goal of Kentucky Physicians Care since its inception in 1985, and

WHEREAS, many outpatients seen by KPC participating physicians did not receive needed medications because they were unable to afford the cost of prescriptions, and

WHEREAS, Pfizer, Inc/Roerig Labs displayed a high degree of social consciousness by making its entire product line available to eligible KPC outpatients at no charge, now therefore be it

RESOLVED, that the Kentucky Medical Association does hereby extend its appreciation to Pfizer/Roerig for this exemplary service, and particularly to corporate officers William C. Steere, President, and Peter G. Tombros, Executive Vice President, whose foresight and sensitivity to the plight of the indigent resulted in this unprecedented and generous commitment, and be it further

RESOLVED, that the KMA recognize Charles L. Hardwick, Vice President for Civic Information, and Deborah Smith-Callahan, RN, Government Relations Manager for Pfizer, for their untiring efforts to address, develop, and implement the logistical, technical, and legal considerations necessary in taking this program from a concept to reality, and be it further

RESOLVED, that a copy of this Resolution be sent to the individuals named herein.

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed Resolution B, Recognition of Pfizer, Inc, submitted by the Board of Trustees. The support offered by Pfizer, Inc in conjunction with the Kentucky Physicians Care Program is greatly appreciated, and supports KMA's quest to provide good medical care.

Reference Committee No. 1 recommends that Resolution B be adopted.

Substitute Resolution I

Tax on Liability Insurance Premiums
Jefferson County Medical Society

WHEREAS, the 1990 Kentucky General Assembly amended state law so as to enable local governments to levy a tax on premiums of locally issued insurance policies, and

WHEREAS, a number of Kentucky communities currently are considering the imposition of such a tax, and

WHEREAS, the cost of medical care is a significant factor in lack of access to medical care, and

WHEREAS, the cost of professional liability insurance is a significant factor in the costs incurred by medical practices in the provision of medical care, and

WHEREAS, there are no provisions in the law to exempt professional liability premiums from the tax, and

WHEREAS, such taxes would impose additional overhead costs to medical practices, and

WHEREAS, the cost of such additional taxes inevitably must be passed along to patients and may be expected to, thereby, adversely affect access to medical services, now therefore be it

RESOLVED, that the Kentucky Medical Association make known its concern about the negative impact on access to care which is likely to result from the increased costs imposed by these new taxes on professional liability insurance premiums, and be it further

RESOLVED, that the KMA communicate this concern to state government and support the exemption of professional liability insurance premiums from this tax.

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed Substitute Resolution I, Tax on Liability Insurance Premiums, submitted by the Jefferson County Medical Society. Testimony was heard from members of the Board of Trustees and members of the Jefferson County Medical Society. It was the feeling of Reference Committee No. 1 that an exclusion of a single type of insurance from taxes is not in the best interest of the Association as a whole.

Reference Committee No. 1 recommends that Substitute Resolution I be rejected.

Resolution N

AMA Accountability
Jefferson County Medical Society

WHEREAS, misguided and unfortunate top-level administrative decisions at the American Medical Association led to financial mismanagement and administrative restructuring, and

WHEREAS, the AMA House of Delegates at its Interim 1989 and Annual 1990 Sessions expressed grave concern over these events, and demanded full accountability and assurance that such fiscal inconsistencies should not be repeated, and

WHEREAS, these errors, although reportedly resolved, could cause young physicians to become skeptical about their identification with medical professional organizations, and

WHEREAS, current KMA and AMA members might also be forced to reconsider their degree of participation and membership support, now therefore be it

RESOLVED, that the Kentucky Delegation to the American Medical Association House of Delegates exercise the

policy-setting and administrative means available to it to urge that the American Medical Association inform its members regarding salaries and AMA benefits with respect to top-echelon AMA employees on a regular basis.

Recommendations, Reference Committee 1:

Reference Committee No. 1 reviewed Resolution N, AMA accountability, submitted by the Jefferson County Medical Society. Testimony was heard from the KMA's Senior Delegate to the AMA, and from members of the Jefferson County Medical Society. The Jefferson County Medical Society submitted a substitute "Resolved" to its Resolution, to read:

> **"RESOLVED, that the KMA's Senior Delegate to the AMA House of Delegates obtain information regarding salaries and AMA benefits with respect to top-echelon AMA employees, and make this information available to the KMA Board of Trustees on a timely basis, which in turn will make it available to any KMA member upon request."**

After review of this substitute "Resolved," and of a similar Resolution adopted by the AMA House of Delegates (Substitute Resolution 83, A-90), Reference Committee No. 1 recommends that Resolution N be adopted as amended.

Mr. Speaker, Reference Committee No. 1 recommends adoption of the Report of Reference Committee No. 1 as a whole.

Mr. Speaker, I want to thank the members of Reference Committee No. 1 who worked hard to assist the House of Delegates on these matters. Members of the Committee were Ralph D. Caldroney, MD, Lexington; David B. George, MD, Lebanon; G. Randolph Schrodt, MD, Louisville; and Don R. Stephens, MD, Cynthiana. I would also like to thank Debby Traughber for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 1

Michele Redden-Borowski, MD, Covington, Chairman
Ralph D. Caldroney, MD, Lexington
David B. George, MD, Lebanon
G. Randolph Schrodt, MD, Louisville
Don R. Stephens, MD, Cynthiana

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 2

Daniel E. Kenady, Sr, MD, Lexington, Chairman

13. Report of the Scientific Program Committee
14. Report of the Scientific Exhibits Committee
15. Report of the Continuing Medical Education Committee
16. Report of the Council for Continuing Medical Education
17. Report of the Cancer Committee
18. Report of the Emergency Medical Care Seminar Planning Committee
19. Report of the Physician Manpower Committee
20. Report of the Interspecialty Council
21. Report of the Committee on Faculty Physicians
22. Report of the Hospital Medical Staff Section
    - Resolution A — Medical use of Laser Technology (Northern Kentucky Medical Society, Inc)
    - Resolution C — CME Activities (Board of Trustees)
    - Resolution L — Medical Use of Laser Technology (Fayette County Medical Society)
    - Resolution Y — Radon Action Week (Jefferson County Medical Society)
    - Resolution AA — Medical use of Laser Technology (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 2 reviewed the following items and recommends they be filed, by the consent of the House, without discussion:

13. Report of the Scientific Program Committee — filed
14. Report of the Scientific Exhibits Committee — filed
15. Report of the Continuing Medical Education Committee — filed
16. Report of the Council for Continuing Medical Education — filed
17. Report of the Cancer Committee — filed
18. Report of the Emergency Medical Care Seminar Planning Committee — filed
19. Report of the Physician Manpower Committee — filed
20. Report of the Interspecialty Council — filed
21. Report of the Committee on Faculty Physicians — filed
22. Report of the Hospital Medical Staff Section — filed

Mr. Speaker, Reference Committee No. 2 recommends adoption of the Consent Calendar as a whole.

Report of the Scientific Program Committee

"A New Decade — Pride in Medicine" was selected by the Scientific Program Committee as the overall theme for the 1990 KMA Annual Meeting Scientific Program. This is a three-day program featuring general scientific presentations each morning and specialty group meetings each afternoon. The topics to be presented during the sessions were developed based on a survey of the KMA membership, evaluations from last year's meeting, and the perspective of various specialties participating in the meeting. The Committee members and representatives from the 23 specialty societies have worked hard to bring some of this country's outstanding speakers to the meeting, and it is hoped that the membership will find their presentations useful.

The KMA Annual Meeting will be held at the Hyatt Regency Hotel/Commonwealth Convention Center in Louisville. This is the first year the program has been held at the Commonwealth Convention Center which offers ample meeting space for morning sessions, afternoon specialty group meetings, and the technical exhibit hall which plays an important part in the Scientific Program. We urge members to visit the exhibits which offer opportunities to discuss new products and become familiar with new equipment free from the interruptions or distractions of the office or hospital.

I would like to thank all those who have assisted in the development of this program, particularly the Program Committee, specialty group presidents, and program chairmen. I especially want to thank Donna M. Young and Beth Thomas, members of the KMA staff, for their diligent work in making the Scientific Program the outstanding success that it enjoys. The Committee always welcomes suggestions for future programs.

James A. Baumgarten, MD
Chairman

Report of the Scientific Exhibits Committee

In 1989 there were eight scientific exhibits approved by the Scientific Exhibits Committee. The following exhibits were permitted during the 1989 Annual Meeting:

Palliative Management of Lung Cancer
Sibu P. Saha, MD, and Anthony G. Rogers, MD
Diabetic Retinopathy
Charles F. Mahl, MD
Gallstone Lithotripsy
Kenneth R. Kranz, MD, and Mark A. Malangoni, MD
Kentucky Cancer Program
Markey Cancer Center
Kentucky Cancer Program
Brown Cancer Center
Physician Communications — "The Next Generation"
University of Kentucky Medical Center
Kentucky's Profile: Department for Health Services
Preconceptional Health Risk Appraisal Project
Department for Health Services/Family Planning Program
Kentucky Sexual Assault/Abuse Medical Protocol
Victims Advocacy Division/Attorney General's Office

The Scientific Exhibits Committee will accept applications from physicians wishing to present appropriate exhibits for display at the KMA Annual Meeting. It is a policy of the Committee not to accept institutional scientific exhibits unless the exhibit will render a service to the physicians of Kentucky and contains no promotional features.

In the future we intend to enforce this policy by prohibiting the name of the facility on the booth header and permitting physician's name and title of exhibit only.

The Committee continues to urge physicians to utilize the scientific exhibits area and encourages attendance at the Annual Meeting to observe the exhibits.

Richard A. Kielar, MD
Chairman

Report of the Continuing Medical Education Committee

It was a rewarding year for the Continuing Medical Education (CME) Committee. Two years ago when I assumed the chair of this Committee, the Committee was charged with revitalizing the CME accreditation program, its structure, and the process utilized in reviewing providers as directed by the Accreditation Council for Continuing Medical Education (ACCME). These new procedures and policies have been in place for the past two years and now the focus is on "fine tuning" the program.

In May, the Committee and staff met with members of a survey team from the ACCME (Sue Ann Capizzi, Illinois State Medical Society, and Winston P. Caine, Jr, MD, Chattanooga, TN) as part of KMA's reaccreditation process. The survey team reviewed a detailed application from the Committee containing all documentation and correspondence from organizations currently accredited, written policies and procedures, records and minutes from the Committee meetings, yearly reports from accredited organizations, and guidelines and training materials used in the CME process. Discussion with the survey team indicated that KMA has made exceptional progress in its efforts to assure the availability of quality CME programs throughout hospitals in the state. KMA will be notified in the fall of its reaccreditation status. Based on the comments of the surveyors, a positive report is anticipated.

During the past year, two hospitals have completed written applications and participated in on-site surveys of their facilities by survey teams composed of one or two CME committee members and a KMA staff person. Good Samaritan Hospital and St. Joseph Hospital, both in Lexington, were each awarded two years accreditation. At this time, eight hospitals are accredited by KMA. They are: Central Baptist Hospital, Lexington; Good Samaritan Hospital, Lexington; King's Daughters' Medical Center, Ashland; Lexington Clinic, Lexington; Louisville Area CME Consortium, Louisville; St. Joseph Hospital, Lexington; Saints Mary and Elizabeth Hospital, Louisville; and St. Elizabeth Medical Center, Edgewood.

Last November, the Committee sponsored a seminar to introduce new committee members and hospital CME chairmen and directors to the accreditation process. Frances Maitland, a representative from the ACCME, was invited as one of the guest speakers to explain the role of the ACCME and to answer specific questions relating to the accreditation

process. The Committee will continue to sponsor seminars periodically as an orientation session for new committee members and for hospital personnel involved in CME program development.

Along these same lines, the Committee has recommended to the Board of Trustees that KMA reaffirm its commitment to educational responsibility as stated in KMA's Constitution; and that all hospitals in the Commonwealth be encouraged to actively support and participate in the process of accredited CME activities.

This year, the Committee also reviewed nominations which were solicited for the Educational Achievement Award. This award may be made annually, and is given to individuals who have made outstanding contributions in medical education in the clinical, scientific, or public health areas. The award will be presented during the first meeting of the House of Delegates in September.

As Chairman, I would like to thank the Committee members, who continue helping bring about the revitalization of the CME Committee and who spend many hours reviewing applications and visiting hospitals as part of the accreditation process, and especially the staff of KMA, without whose efforts any progress would be impossible. The Committee urges any member who has an interest in CME to contact the Committee and assist in these efforts. Once again, we thank the Board of Trustees for its support in allowing the Committee the opportunity to refine and improve the accreditation process for continuing medical education in Kentucky.

Larry P. Griffin, MD
Chairman

Report of the Council for Continuing Medical Education

The Continuing Medical Education (CME) Council was involved in two major projects this year. As the provider arm of the Association's CME activities, the Council is responsible for accrediting the Scientific Program of the Annual Meeting. To ensure that the program topics offered meet the learning needs of physicians, the Council conducted a needs assessment survey of the KMA membership. The results of this survey were used in planning the 1990 Scientific Program. Responses from members indicated an interest in presentations on AIDS, environmental issues, medical ethics, and substance abuse. These topics, along with many others, will be presented as part of the overall scientific sessions for 1990.

This year the Council submitted its annual report to the Accreditation Council for Continuing Medical Education (ACCME) to address specific areas that need to be revised as suggested by the ACCME. The annual report included a revised mission statement which describes the goals, the scope, and the type of CME activities provided by KMA. As stated in the mission statement, the goals of the CME program are to initiate, develop, coordinate, and implement CME offerings based on the general and specific needs of the physician population of Kentucky. After receiving the report, the ACCME commended the KMA for its continued efforts to offer a quality Scientific Program.

As Chairman, I would like to thank the Council members for their dedication and interest. The Council will continue to strive to ensure the standards of a quality CME program.

James A. Baumgarten, MD
Chairman

Report of the Cancer Committee

It has been an active year for the Cancer Committee, which met twice. During the first meeting, Committee members were asked to consider two bills, both dealing with mammography, being introduced during the 1990 Kentucky General Assembly.

SB 41 — This bill will allow the development of breast cancer screening programs in the state for people who do not have access to mammography because of geographic distance or inability to pay. This bill also declares the establishment of a Cancer Registry and funding of a Cancer Patient Data Management System (CPDMS).

HB 62 — This bill will require all insurors issuing individual and group health insurance policies in Kentucky which provide coverage for surgical services for a mastectomy to also provide coverage for low-dose mammography screening. The coverage will make available one screening mammogram for persons aged 35 through 39; one mammogram every two years for persons aged 40 through 49; and one mammogram per year for persons aged 50 and over. Coverage is limited to a benefit of $50 per mammogram.

At the Committee meeting in April following the General Assembly, it was reported that both of these bills had passed. It was the decision of the Committee to monitor HB 62 between now and the 1992 General Assembly to determine its impact.

Another bill which passed the General Assembly was discussed. HB 628 prohibits the sale of tobacco products to anyone under the age of 16. It also requires that signs be posted concerning the prohibition. Other provisions of the bill call for smokers' rights, which prohibit employment discrimination or any requirements that a smoker abstain from tobacco use outside the course of employment.

Along these same lines, the Committee will conduct a survey of the KMA membership to determine physicians' views on smoking. Questions to be asked are: (1) Do you use tobacco products? (2) Is your office smoke-free? (3) Do you favor smoke-free hospitals or a policy for smoke-free hos-

pitals? and (4) Do you need additional help or materials for counselling your patients to stop smoking? Findings from this survey will be discussed at the fall Cancer Committee meeting and may result in recommendations to the KMA Board of Trustees concerning tobacco legislation in 1992.

At the last meeting of the Cancer Committee, discussion focused on the Cancer Patient Data Management System (CPDMS) which, as reported earlier, will receive funding as a result of SB 41. CPDMS was developed by the Kentucky Community Cancer Program and is a comprehensive system for collecting, managing, and analyzing information related to the diagnosis and treatment of cancer patients in Kentucky. It provides individual hospitals with the ability to monitor the type of cancer patients seen, the extent of disease at diagnosis, type of diagnostic procedures used, and type of therapy provided. Thirty-two state institutions are participating in the program and there are 11 geographic areas collecting information on 60% of the cases in Kentucky. The Committee will be submitting articles to the *Journal* of the KMA explaining the purposes, objectives, and findings regarding this program for dissemination to KMA members.

As Chairman, I would like to thank the Committee members for their dedication. The Committee appreciates the opportunity to be of service to the Association.

Clinton C. Cook, III, MD
Chairman

Report of the Emergency Medical Care Seminar Planning Committee

This year marks the final program of the Emergency Medical Care Seminar. As reported last year, KMA will no longer sponsor the seminar, mainly as a result of specialization in all areas of continuing education. It has become difficult to plan a program that meets the educational requirements of a diverse audience of physicians, nurses, paramedics, and EMTs. Each group has become very specialized and, as a result, training requirements must be designed to meet specific education needs.

Approximately 100 participants attended this year's meeting which was held at Lake Barkley State Resort Park for the first time. It was felt that the new site offered opportunities to those who had not previously been exposed to the seminar. The program offered a variety of topics on trauma injuries, gunshot wounds, and alcohol and substance abuse. Guest speakers included: Edmond A. Hooker, MD, Louisville; Francis L. Buono, MD, Bowling Green; David M. West, MD, Paducah; Gregory L. Brown, MD, Louisville; Mary A. Smith, MD, Louisville; Terrell D. Mays, MD, Elizabethtown; George C. Rodgers, MD, Louisville; John D. Noonan, MD, Paducah; Gregory J. Davis, MD, Louisville; Ardis D. Hoven, MD, Lexington; Charles R. Oberst, MD, Louisville; David Miller, MD, Louisville; Bradford E. Mutchler, MD, Paducah; R. Quin Bailey, MD, Danville; Diller B. Groff, MD, Louisville; James R. Roush, MD, Paducah; Wally O. Montgomery, MD, Paducah; and Burns M. Brady, MD, Louisville.

Also attending the meeting were exhibitors from Physio-Control, Armstrong Medical Industries, Kentucky Organ Donor Affiliates, STATFLIGHT, Emergency Medical Supply, and the Emergency Nurses Association.

During the seminar, Ardis D. Hoven, MD, presented an award to Cheryl Westbay, RN, on behalf of the KMA Board of Trustees, which stated, "For her dedication, service, and unselfish commitment to the promotion of quality medical care through her efforts in producing the Emergency Medical Care Seminar." (The Board of Trustees also presented E. Truman Mays, MD, with a plaque for his 20 years as Chairman of the planning committee.)

The Chairman would like to thank the Kentucky Medical Association for its continued support, particularly from those physicians who have participated as faculty for the Seminar. It has been a pleasure serving as Chairman and I would like to take this opportunity to applaud the efforts of the members of the planning committee who contributed to the seminar's success. The members are: Donald E. Barker, MD, Lexington; James L. Combs, MD, Burlington; Diller B. Groff, MD, Louisville; J. David Richardson, MD, Louisville; Charles B. Spalding, MD, Bardstown; Donald M. Thomas, MD, Louisville; Barbara Cox, RN, Louisville; and Cheryl Westbay, RN, Louisville.

On behalf of the Committee, we are grateful to the KMA House of Delegates and the KMA Board of Trustees for their support during the last 20 years.

E. Truman Mays, MD
Chairman

Report of the Physician Manpower Committee

The Physician Manpower Committee met twice this year in an effort to determine the state's current and future manpower needs as directed by the KMA Board of Trustees.

This year the Committee, along with the state Department for Health Services, conducted a survey of physicians recently licensed in Kentucky. The purpose was to examine the factors that motivate physicians to choose either urban or rural practice, assuming that this information might help in formulating measures to reduce the number of counties in Kentucky with shortages of primary care physicians. A similar survey was conducted in 1988, but the results were inconclusive. The decision was made to repeat the survey using a sample size large enough to ensure statistical validity.

Physician responses from the second survey consistently emphasized personal and professional factors as the chief influences on their practice location decisions. These findings are in contrast to similar studies in other states

where results indicated that the two major influences on practice location were: (1) residency training location; and (2) medical school location.

To summarize the highlights of the survey, the factors most strongly influencing a primary care physician's decision on where to practice were: (1) a good environment for rearing children, especially good local schools; (2) convenient access to a good hospital in an area that needs the physician's specialty; (3) an area with reasonable cultural amenities, preferably similar to the area in which the physician grew up; and (4) support from and cordial professional interaction with other area physicians.

During the past two years, the Committee has considered Kentucky's physician manpower situation using data available from a study conducted by the Graduate Medical Education National Advisory Council (GMENAC), which projected an excess of physicians nationwide by the year 1990. In Kentucky, however, there is not an excess of physicians; but there is a serious problem of maldistribution.

Both medical schools are making efforts to remedy the situation. Clinical training for students and residents in the rural areas of the state is being promoted by both medical schools with increased recruitment efforts directed to high school students, particularly in rural areas. These efforts will be intensified as a result of legislation passed during the 1990 Kentucky General Assembly that allows development of and funding for physician recruitment and placement services at both medical schools.

Along these same lines, the Physician Manpower Committee with the help of Joel Shanklin, medical student at the University of Louisville, is developing an informational packet and slide presentation to be used by physicians, residents, and medical students who volunteer to visit high schools throughout Kentucky encouraging students to choose medicine as a career. The Committee will also contact the AMA which is developing a video designed for recruiting high school students that focuses on interviews with medical students and their reasons for choosing medicine as a career, along with tips on how to apply to medical school.

As Chairman, I would like to thank the Committee members for their interest and time. The Committee will continue to study and review data to determine the needs of physician manpower in Kentucky.

Robert R. Goodin, MD
Chairman

Report of the Interspecialty Council

Activities of the Interspecialty Council were carried out through correspondence this year. The Interspecialty Council is composed of 25 specialty groups, with each group appointing one representative to the Council, and the Chairman being appointed by the Board of Trustees.

We are pleased to announce the addition of the Kentucky Geriatrics Society to the Interspecialty Council. The mission of the Kentucky Geriatrics Society is to encourage and enhance all geriatric activities among the physicians and other professionals of Kentucky to help ensure appropriate comprehensive care necessary for the best quality of life for the elderly citizens of Kentucky.

To be eligible for entry into the Kentucky Medical Association Interspecialty Council, all specialty groups must meet the following criteria:

A. Specialty groups must have a national or parent organization.
B. Specialty groups, to be recognized, may or may not have a separate and distinct certifying board.
C. The state society applying for recognition must first have formal affiliation with its national counterpart.
D. A specialty group must be a primary specialty or "major" subspecialty in terms of delineated scientific knowledge within the realm of the discipline of medicine.
E. The specialty group must have sufficient membership or potential membership to make worthy and significant contributions to the KMA Annual Meeting, to be decided by the KMA Executive Committee.

This past year services have been provided to: the Kentucky Chapter, American College of Radiology; the Kentucky Society of Internal Medicine; the Kentucky Orthopaedic Society; and the Kentucky Society of Anesthesiologists. These services include promotion of programs, surveys, mailings, and correspondence.

If the Interspecialty Council can be of service to the members of the Kentucky Medical Association, please let us know. We thank the KMA Board of Trustees and members for their support.

Bob M. DeWeese, MD
Chairman

Report of the Committee on Faculty Physicians

At its September 1988 Annual Meeting, the Kentucky Medical Association House of Delegates adopted a Resolution calling for an investigation and report on the activities of medical school faculty members and their role in fulfilling the educational mission of medical schools in Kentucky. An Ad Hoc Committee on Faculty Physicians was subsequently appointed to deal with the issues delineated in the Resolution.

After several meetings of the Ad Hoc Committee and review of a great deal of information and material, the consensus was that both Kentucky medical schools share in the nationwide problem of shrinking research grants and re-

duced public subsidy to medical schools, being forced to generate funds from the private practice of medicine in order to hire and retain quality faculty members. This obviously caused a conflict between the faculty and private practice physicians, magnified by a lack of communication between faculty and the private sector.

In order to facilitate a free and productive flow of communication between the faculties of the medical schools and the private sector, the Ad Hoc Committee on Faculty Physicians recommended that KMA create a standing committee to meet as needed to discuss any problems and/or conflicts between the medical schools and private practice physicians. It further recommended that the standing committee be divided into two subcommittees representing the Louisville and Lexington areas, respectively.

The Board of Trustees accepted the report submitted by the Ad Hoc Committee last year and appointed a standing Committee on Faculty Physicians to serve the Association in resolving any problems or areas of conflict.

We are pleased to report that no problems were reported to the Committee on Faculty Physicians during this Associational year. Perhaps this was due to the extensive investigation previously conducted. Perhaps avenues of communication have been opened and problems are being resolved on an individual basis.

The Committee on Faculty Physicians stands ready to be of service to the Association whenever the need arises. We feel the Committee should continue to exist and that the very existence of the Committee on Faculty Physicians is serving a vital purpose.

Robert R. Goodin, MD
Chairman

Report of the Hospital Medical Staff Section

The Hospital Medical Staff Section (HMSS), established in 1984 to provide a forum for discussion of mutual problems of hospital medical staffs, continues to see a growing number of hospital medical staffs certifying representatives to the Section. Participation by those representatives in activities of the Section is also increasing.

Due to KMA involvement with the Kentucky General Assembly this year, we found it necessary to schedule the Annual Meeting of the HMSS later than usual in the year. The Steering Committee met in May to plan this year's Section Meeting for August 30, 1990. The Steering Committee works toward planning educational programs each year that will include information for physicians that is vital to their individual practices and their function as members of the medical staff of their hospitals.

We believe an excellent program has been planned for the 1990 HMSS Annual Meeting. We are pleased that KMA President Nelson B. Rue, Jr, MD, will be participating in this year's program. An excellent slide presentation on the 1990 Kentucky General Assembly, developed by KMA's State Legislative Chairman, Wally O. Montgomery, MD, will be shared by Doctor Montgomery, and specific legislation which has a direct impact on the practice of medicine will be discussed.

Marva Gay-Callahan, Esq, Vice President of the Kentucky Hospital Association, will present information on the Consolidated Omnibus Budget Reconciliation Act (COBRA).

Jeffrey Rice, MD, Medical Director of the Sentinel Medical Review Organization, has been asked to attend this year's meeting in follow up to the presentation last year by a representative of Sentinel. Doctor Rice will be asked to discuss some of the problem areas that exist for physicians in dealing with Sentinel and Sentinel's plans to resolve those problems.

The National Practitioner Data Bank will be a major part of this year's program. Sharon J. Swan, Program Administrator with the AMA Department of Hospital Medical Staff Services and KMA's contact, will present information on the National Practitioner Data Bank from the point of view of a physician and medical staff member, and Marva Gay-Callahan will also participate in a segment of the National Practitioner Data Bank presentation by providing the hospital's perspective. A question-and-answer session will follow which will provide those in attendance with an opportunity to obtain answers to any specific questions.

Another portion of the program will be a "Health Care Law Update." KMA Legal Counsel, Charles J. Cronan, IV, will present timely information and answer any specific questions.

The business portion of the HMSS Annual Meeting will provide those attending with generic information on activities with various hospital medical staff members of the HMSS during the year. Three positions on the Steering Committee are to be filled this year by election. The HMSS Nominating Committee has proposed the name of Rex Cox, MD, Louisville, for election to the position of Secretary. Proposed for the two positions of Member at Large are Robert Emslie, MD, Madisonville, and William O'Bryan, MD, Owensboro. All positions are for three-year terms. Nominations will also be accepted from the floor. Steering Committee members holding other positions will remain on the Committee filling unexpired terms.

The Steering Committee would like to thank James Russell, MD, Lexington, Chairman, and the other members of the 1989-90 HMSS Nominating Committee, for their dedicated work in selecting candidates for these positions. Other members of the Nominating Committee were Susan C. Echterling, MD, Ashland; Robert Emslie, MD, Madisonville; Theodore Lynch, MD, Louisville; and Susan Spires, MD, Lexington.

Names being proposed by the Steering Committee for election by the Section as the 1990-91 HMSS Nominating Committee are John J. Buchino, MD, Louisville; Syed Badrudduja, MD, Prestonsburg; Mary R. Johnson, MD, South Wil-

liamson; Steve S. Kraman, MD, Lexington; and H. Michael Oghia, MD. Columbia.

Several KMA-HMSS members attended the annual meetings of the AMA and the AMA Hospital Medical Staff Section in June of this year. A number of topics were discussed which are important to physicians, as medical staff members. While much of the information from the AMA Annual Meeting will be contained in the Report of the KMA Delegation, I would like to call your attention to some of those matters through a brief summary.

The AMA House of Delegates has been concerned with the problems of access to rural health care. Report K of an Ad Hoc Committee on Rural Health set five priorities for future attention to this matter. The AMA House, in adopting Report K, set policy to "encourage legislation to reduce financial constraints on small rural hospitals in order to improve access to health care."

Additional action in this area by the AMA House, prompted by concern with the current DRG reimbursement system to rural hospitals, recommended that when it is in the best interest of their patients, physicians and hospitals be encouraged to transfer patients back to hospitals in their home communities and that AMA support any needed revisions in Medicare regulations to allow reimbursement for those transferred patients. Further action called for the elimination of geographic variations in Medicare payment that do not reflect demonstrable variations in practice overhead or professional liability costs. Additional recommendations regarding Medicare payments were also adopted.

Other Medicare issues receiving action by the AMA House of Delegates included: Medicare interference in patients privately contracting with their physician for wanted or needed health services; OBRA '89 requirements for all physicians to submit Medicare claims on behalf of their patients beginning September 1, 1990; Medicare's "Comparative Performance Report" Program; Medicare's maximum allowable actual charge (MAAC); and Medicare's discount of physicians seeing more than one patient at the same nursing home visit.

The AMA House of Delegates also addressed issues on utilization review, to include ERISA requirements; due process, including HCFA interpretations on condidentiality in PRO hearings and notification of denials by PROs and physician appeals; and called for repeal of HCFA's mandated peer review organization preprocedure certification requirement.

The AMA Hospital Medical Staff Section, at its June meeting, passed a number of resolutions that will be considered by the AMA House of Delegates at its 1990 Interim Meeting in December. These included:

Resolution 52, Risk for Hospital Medical Staff Physicians, reaffirming AMA policy for full indemnification and hold harmless for medical staff administrative functions;

Resolution 56, Third-Party Payors and Patient Care Standards, calling for hospital medical staffs to have primary responsibility for establishment and enforcement of all medical quality standards within their institution;

Resolution 17, Denial of Payment for Preexisting Condition, calling for AMA to support developing changes in health insurance to minimize or eliminate the risk of nonpayment for preexisting conditions for an individual who wishes to change health care coverage to a different policy;

Resolution 29, Medicare Physician Qualifications Act of 1990 (HR 4464), encouraging AMA to oppose HR 4464 which would require physicians treating Medicare patients to pass periodic proficiency exams as a condition for payment.

Additional issues discussed which would be of interest to medical staff members dealt with other areas of PROs, Medicare, third-party payors, and the National Practitioner Data Bank. Information on these matters, as well as a more detailed report on the issues briefly discussed above, will be provided to those attending the KMA-HMSS Annual Meeting in August.

As Chairman of the KMA Hospital Medical Staff Section, I would like to take this opportunity to express appreciation to the medical staffs and Section representatives of those hospitals who have chosen to participate in the KMA-HMSS. I am also grateful for the dedication of the members of the Steering Committee for their efforts to make the HMSS an effective KMA activity. Those members are Earl P. Oliver, MD, Scottsville, Vice Chairman; Roderick H. MacGregor, MD, Bedford, Secretary; David R. Watkins, MD, Louisville, Delegate; Harold L. Bushey, MD, Barbourville, Alternate Delegate; and James G. Kuhns, MD, Louisville, and John D. O'Brien, MD, Louisville, Members at Large.

We will continue working toward our goal of having active participation from the medical staff of each eligible hospital in Kentucky. This is a positive step toward assuring good working relationships between physicians and hospitals, and I urge each physician to see that the medical staff at his or her hospital becomes actively involved in the HMSS and all KMA activities.

Donald J. Swikert, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Resolution C

CME Activities
Board of Trustees

WHEREAS, one of the primary purposes of this Association, as stated in the Constitution, is to extend medical knowledge, advance medical science, and evaluate standards of medical education, and

WHEREAS, a constant search for expansion of medical knowledge is intrinsic to the medical profession and is the time-honored pursuit of each individual physician, and

WHEREAS, Kentucky was one of the founding medical associations for a structured, formalized process of accrediting institutions to provide timely and worthwhile CME opportunities for physicians, and

WHEREAS, one of the most effective sites for disseminating medical knowledge is in the primary clinical setting of care delivery, the hospital, and

WHEREAS, many health care delivery facilities have assumed the obligation of CME provider through the formal accreditation process managed by this Association with the supervision of the Accreditation Council for Continuing Medical Education, now therefore be it

RESOLVED, that KMA reaffirm its deep commitment to its educational responsibility on behalf of the profession, and be it further

RESOLVED, that KMA encourage all hospitals in the Commonwealth to expand their implicit educational partnership with physicians by actively supporting and participating in the process of accredited CME activities.

Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed Resolution C, CME Activities, introduced by the Board of Trustees. Reference Committee No. 2 recommends that Resolution C be adopted.

Resolution Y

Radon Action Week
Jefferson County Medical Society

WHEREAS, exposure to radon poses a serious threat to the health of the citizens of Kentucky, and

WHEREAS, the Environmental Protection Agency estimates that lung cancer attributable to radon exposure causes approximately 20,000 deaths a year in the United States, and

WHEREAS, the United States has set a long-term national goal of making the air inside buildings as free of radon as the atmosphere, and

WHEREAS, any home, school, or building may have elevated levels of radon, even if neighboring structures do not, and

WHEREAS, testing for elevated levels of radon gas is simple and inexpensive, and

WHEREAS, excessively high levels in homes and schools can be reduced successfully and economically with appropriate treatment, and

WHEREAS, the citizens of the Commonwealth should be encouraged to conduct tests for radon in their homes to reduce excessive radon levels, now therefore be it

RESOLVED, that the Kentucky Medical Association endorse and support the proclamation of October 14-20, 1990, as Radon Action Week in Kentucky, and be it further

RESOLVED, that KMA participate in public awareness activities by providing radon information to KMA members so that physicians, in turn, can inform their patients about the health risks associated with radon and preventive steps available to measure and economically reduce excessive radon levels.

Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed Resolution Y, Radon Action Week, introduced by the Jefferson County Medical Society. Reference Committee No. 2 recommends that Resolution Y be adopted.

Resolution A

Medical Use of Laser Technology
Northern Kentucky Medical Society, Inc.

WHEREAS, the indication for the use of laser in the treatment of disease is ever-increasing, and

WHEREAS, potential harm to patients exists by the inappropriate use of laser treatment by unqualified practitioners, now therefore be it

RESOLVED, that the Kentucky Medical Association establish an advisory panel for laser therapeutics to assist in professional public education, legislative decision making, and policy development, and be it further

RESOLVED, that the Kentucky Medical Association keep the Kentucky Board of Medical Licensure abreast of changes in this new technology and the medical and surgical expertise required to be utilized in such technology, and be it further

RESOLVED, that the Kentucky Medical Association assure its members and the public that laser use in the treatment of disease will be included in the Kentucky statutes as the practice of medicine.

Resolution L

Medical Use of Laser Technology
Fayette County Medical Society

WHEREAS, the indication for the use of laser in the treatment of disease is ever increasing, and

WHEREAS, the potential harm to patients exists by the inappropriate use of laser treatment by unqualified practitioners, now therefore be it

RESOLVED, that the Kentucky Medical Association establish an advisory panel for laser therapeutics to assist in professional and public education, legislative decision-making and policy development, and be it further

RESOLVED, that the Kentucky Medical Association assure its members and the public that laser use in the treatment of disease will be included in the Kentucky Revised Statutes as the practice of medicine.

Resolution AA

Medical Use of Laser Technology
Board of Trustees

WHEREAS, the use of laser technology in surgery constitutes the practice of medicine, now therefore be it

RESOLVED, that KMA ask the Kentucky Board of Medical Licensure to exercise its statutory authority to monitor the use of laser surgery in the practice of medicine and surgery, and be it further

RESOLVED, that KMA offer to assist the Kentucky Board of Medical Licensure in addressing the issue of laser technology.

Recommendations, Reference Committee 2:

Reference Committee No. 2 reviewed Resolution A, Medical Use of Laser Technology, introduced by the Northern Kentucky Medical Society, Inc; Resolution L, Medical Use of Laser Technology, introduced by the Fayette County Medical Society; and Resolution AA, Medical Use of Laser Technology, introduced by the Board of Trustees.

Reference Committee No. 2 recommends that Resolution AA be amended as follows. A new "Resolved" should be added before the existing "Resolveds" to read as follows:

"RESOLVED, that the KMA assist in professional and public education on the use of laser treatment of humans, and be it further"

Reference Committee No. 2 further recommends that the next "Resolved" be revised by deleting the phrase "and surgery." The amended Resolution will then read as follows:

"RESOLVED, that the KMA assist in professional and public education on the use of laser treatment of humans, and be it further

RESOLVED, that the KMA ask the Kentucky Board of Medical Licensure to exercise its statutory authority to monitor the use of laser surgery in the practice of medicine ~~and surgery~~, and be it further

RESOLVED, that KMA offer to assist the Kentucky Board of Medical Licensure in addressing the issue of laser technology."

Reference Committee No. 2 recommends that Resolution AA be adopted, as amended, in lieu of Resolutions A and L.

Mr. Speaker, Reference Committee No. 2 recommends the adoption of the report of Reference Committee No. 2 as a whole.

Mr. Speaker, I would like to thank the other members of the Committee: Harry W. Carter, MD, Covington; Kela J. Lyons (MSS), Louisville; Ronald E. Waldridge, MD, Shelbyville; and Larry J. Wilson, MD, Louisville, for their time spent in listening to testimony and for their opinions and assistance in preparation of this Committee report. I would also like to thank our secretary, Beth Thomas.

Respectfully submitted,
REFERENCE COMMITTEE NO. 2

Daniel E. Kenady, Sr, MD, Lexington, Chairman
Harry W. Carter, MD, Covington
Kela J. Lyons (MSS), Louisville
Ronald E. Waldridge, MD, Shelbyville
Larry J. Wilson, MD, Louisville

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 3

John D. Stewart, MD, Lexington, Chairman

23. Report of the Maternal Mortality Study Committee
24. Report of the Committee on National Legislative Activities
25. Report of the Committee on State Legislative Activities
26. Report of the Committee on Impaired Physicians
27. Report of the Committee on Care for the Elderly
5. Report of the Chairman, Board of Trustees, Report of the Ad Hoc Committee on Professional Liability Insurance, **only**
   - Resolution F — Living Wills/Health Care Surrogate (Fayette County Medical Society)
   - Resolution M — Physician Candidates for Public Office and Third-Party Positions (Jefferson County Medical Society)
   - Resolution O — Centralized Database for All Prescribed Medications and Drugs in the Commonwealth of Kentucky (Hardin-LaRue County Medical Society)
   - **Special Session on Certificate of Need Issues:**
   - Special Report on Certificate of Need
   - Resolution D — Certificate of Need (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 3 reviewed the following items and recommends they be filed, as indicated, by consent of the House, without discussion:

23. Report of the Maternal Mortality Study Committee — Filed
24. Report of the Committee on National Legislative Activities — Filed
26. Report of the Committee on Impaired physicians — Filed
27. Report of the Committee on Care for the Elderly — Filed
5. Report of the Chairman, Board of Trustees, Report of the Ad Hoc Committee on Professional Liability Insurance, **only** — Filed

Reference Committee No. 3 would like to express its appreciation to the authors of the Reports for the time and effort spent in gathering this information for the House of Delegates. We wish to congratulate the new specialty designation of the Kentucky Geriatrics Society.

Mr. Speaker, Reference Committee No. 3 recommends adoption of the Consent Calendar as a whole.

Report of the Maternal Mortality Study Committee

The Maternal Mortality Study Committee met on September 19, 1989, for two hours at the Hurstbourne Hotel and Conference Center in Louisville, Kentucky. The Committee considered five deaths. The accompanying table outlines pertinent factors in each case. Five cases were discussed at length and it is noted that three of the four cases were classified as obstetric nonpreventable. One was a nonobstetric death which occurred 4½ months after delivery. Thus, this length of time would not classify as a maternal death.

Another topic of discussion was presented by John W. Petry, MD, regarding the document by the American College of Obstetricians and Gynecologists concerning "Legal Protection from Maternal Mortality Review Committees." This was a study conducted by the American College of Obstetricians and Gynecologists concerning immunity of the committees. It was noted that Kentucky is a state that has legal statutes covering members, consultants, and witnesses regarding the confidentiality and legal liabilities of members of the Committee.

Recognition of the work of John W. Petry, MD, should again be given for his devoted efforts to the work of this Committee.

John W. Greene, Jr, MD
Chairman

Report of the Committee on National Legislative Activities

This was an active year for the Committee on National Legislative Activities. The major efforts required were directed to changes and proposed changes to the Medicare program.

A number of changes to the Medicare program went into effect in April. They included a slight increase in the Medicare economic index, updated Maximum Allowable Actual Charges, limits on charges for "overpriced" procedures, and limits on charges for Medicare beneficiaries eligible for Medicaid benefits.

A major piece of legislation this year was the Medicare Physician Regulation Relief Act (HR 4475), introduced by Representative Roy Rowland, MD, (D-GA). Called the "anti-hassle" bill, this legislation seeks to:

Age	Gestational Age	Cause of Death	Committee Opinion
25 y/o G5P2AB1	37 weeks	Death occured 10 days after delivery. Scan showed Massive Subarachnoid Hemorrhage	Non-preventable No autopsy
30 y/o G3P0AB2	33 weeks	Cesarean Section Done Death 6 Days later. Necrotizing hemorrhagic pancreatitis preeclampsia Post renal transplant with renal failure	Non-preventable No autopsy
36 y/o G1P0	31 weeks	Ruptured thoracic aortic aneurysm. Died in intensive care unit. Infant 4 lb. 4 oz. died during neonatal period.	Non-preventable Autopsy obtained
16 y/o G1P0	37 weeks	Gestational diabetes. Weight 220 lbs. Cesarean section performed for failure to progress in second stage of labor. Spinal anesthesia. Anoxic episode after operation rendered her unresponsive — death occurred 11 days later	Anesthesic death questionable factor as to medication received during the operation. Autopsy showed no gross abnormality cause of death anoxic brain damage
38 y/o G2P1	40 weeks	Cesarean Section Done Wgt.: 235 grams	Died 4 ½ months later. Pulmonary embolus.

— require carriers to inform physicians of criteria used to review claims;
— allow physicians to continue coverage of patients of colleagues;
— allow medical associations to appeal denied claims on behalf of a class of physicians;
— establish policy changes and carrier implementation issues;
— prohibit carriers from charging physicians for information necessary to comply with Medicare laws and regulations.

At the time of this writing, there were 111 cosponsors, including two Kentucky Congressmen, Representatives Jim Bunning and Carl Perkins. A companion bill in the Senate is SB 2591. KMA is making intense efforts to get additional Kentucky cosponsors.

Kentucky's Congressional Delegation was also contacted this year to seek support for SB 568, which has passed the Senate, and HR 747, relating to loan deferments for students and residents. Previously, loans could be deferred until the end of the training period under provisions of the Health Education Assistance Loan Program and Guaranteed Student Loan Program. In 1987, both programs were amended to defer payment for two years, and applied only to students who were "in school." This legislation is currently pending.

Another bill that KMA sought support for this year was SB 727, the Animal Research Facility Protection Act. While the medical profession bears some responsibility for helping to educate the public on the necessity for use of animals in biomedical research, this reciprocal legislative effort is necessary to protect facilities. Disruption or destruction of research experiments and facilities may not be specifically listed as a crime in many state criminal codes. (Fortunately, through KMA's state legislative efforts, this issue was addressed in the most recent session of the Kentucky General Assembly.) This bill is currently pending also.

At the beginning of the Associational year, Congress repealed the Catastrophic Health Care Act, which was a portion of the Medicare law. This was a difficult issue for both organized medicine and Congress to deal with because it was an issue of emotionalism to Medicare beneficiaries. While there is a consensus feeling that catastrophic coverage is appropriate for Medicare beneficiaries, the capabilities of the financing mechanism were suspect. Some discussion has been heard about attempting to reinstate this bill, but current concern with further Medicare cuts and revisions would not seem to constitute a favorable atmosphere for this legislation.

A major concern has been implementation of the Clinical Laboratory Improvement Act of 1988. Essentially, this bill extends federal certification to any entity performing laboratory procedures on human specimens. Proposed regulations for the act were published on May 21, with a 90-day comment period. Currently, KMA, together with AMA and most other states, has asked for an extension of the comment period. The provision applying to physician office laboratories allows certificates of waiver if a limited number of tests are done which are categorized as those that pose no reasonable risk of harm to the patient if the test is performed incorrectly.

The next level of regulation, or Level I, would apply to entities performing tests where a reasonable risk of harm to the patient exists if the test is performed incorrectly, and these entities must have as director a physician or PhD. Level II regulations would apply to entities performing tests not included in the first, or waiver, level or Level I tests, and there is a reasonable risk of harm to the patient if the test is performed incorrectly, the risk being substantial for some tests. Directors for facility II labs would have to be clinical pathologists or the equivalent.

The regulations are being opposed because of increased costs, personnel requirements, and proficiency testing specifications that do not warrant this degree of regulation. Also at issue is whether a state or federal mechanism would oversee the implementation of these regulations, and Kentucky has opted for state primacy with the agreement of the Cabinet for Human Resources.

A final legislative effort to be mentioned is the so-called "125%" rule. At the last minute, a provision was inserted in the Budget Reconciliation Act of 1989 which imposed balance billing limits of 125% on all physician services beginning January 1, 1991. This date is one year prior to the implementation of the Resource-Based Relative Value Scale (RBRVS) reimbursement method. The effect is that the RBRVS payments would be considerably lower than anticipated because RBRVS was to be phased in over a five-year period. The effect would be considerable on selected specialties with regard to reimbursement. Currently, KMA is actively involved in seeking Congressional delays of one year before the 125% rule is imposed.

A number of other issues were considered this year of lesser magnitude, both in the legislative and administrative arenas, and routine contact has been maintained with each of the Congressional offices of Kentucky's representatives, as well as through AMA channels. As Chairman, I would like to thank each of the Key Contacts for their efforts and all physicians throughout the state who have voiced their concerns over the many matters that confront medicine daily in Congress.

Donald C. Barton, MD
Chairman

Report of the Committee on Impaired Physicians

The Committee on Impaired Physicians has had an extremely active year. In addition to regular bimonthly meetings, an ad hoc subcommittee has met approximately six

times to deal with acute situations demanding Committee involvement in subject treatment. In addition to case work, the Committee's efforts in reviewing the need for a medical director received considerable attention.

Arising from last year's report, the Committee began implementing the "Doctoring Under the Influence" (DUI) program, which is a voluntary proposal for hospitals and other medical facilities to deal with impaired staff members. This information was disseminated to all Kentucky hospitals and was followed up by visits on request from facilities seeking to implement the proposal.

Solicitations were made again this year for the Benevolent Fund. This Fund was established to help members in need, but thus far has been used exclusively for impaired physician activities. Funds were used this year to help defray acute and outpatient substance abuse treatment and other therapy expenses, and for continuing medical education activities as a practice reentry tool. Over $15,000 was solicited for the Fund this year. All funds expended must be approved by the Executive Committee of the Board of Trustees and are not gifts, but loans, subject to repayment based on a schedule determined by the Committee.

With respect to financing, the Committee has noted this year that acute care insurance coverage for chemical dependence treatment seems to be suffering as new policies are written. A previous standard was provision for a 28-day stay in an acute care facility, but many policies no longer provide this coverage. As a result, the Committee has sought other methods and combinations of methods for dealing with the insurance provisions of individuals with which it deals.

The Committee has noted the increased benefit from the use of counselling as an adjunct to more traditional forms of chemical dependence treatment, and has begun investigating and utilizing various counselling resources. To this point, nearly all the individuals involved have been able to meet these expenses without outside assistance.

The Committee continued its outreach efforts again this year by developing a poster which was sent to all pharmacies and hospitals in the state. The poster alerts the reader to watch for signs of impairment and directs contact with the Committee.

A close working relationship with the Board of Medical Licensure continued this year and has proven very helpful, both to the needs of the Licensure Board and in the interests of the Committee. Most activities have occurred in the form of individuals being referred to the Committee by the Board with the stipulation that licensure status depends on cooperative efforts with the Committee. In addition to three regular, full-time investigators, a special investigator is employed by the Board whose sole duty is to monitor physicians who are acknowledged as having substance abuse problems. For the most part, this monitoring takes the form of the collection of random urine screens, although other monitoring activities are carried out in the form of contacts and ongoing investigations.

Efforts also continue to increase both voluntary and involuntary educational activities in the medical schools on dealing with physician impairment. Work is now being done to establish an impairment evaluation program in each of the major departments at the University of Louisville, and a local, in-house videotape was developed at U of L to help with this work. Routine contacts are made with the curriculum committees at both schools to try to expand substance abuse identification and treatment information.

A few years ago, the Committee had preliminary discussions about the possibility of acquiring a full-time medical director for the impaired physicians program. It became apparent that the key ingredients for a medical director were the need, based on work load; the ability to fund such a program; and the existence of a fairly strong program based on committed volunteers located throughout the state. The issue remained essentially under study until this year, when a closer analysis was made with a view to settle the question.

An informal review of programs of other states, by word-of-mouth and through literature, indicates that the Kentucky program is fairly effective, considering the funding allotted and the fact that all work is done on a voluntary basis. However, as time has passed, the type of work required has become more sophisticated in terms of monitoring and serving in an advocacy position to the Board of Medical Licensure, to liability insurers, to hospital medical staffs, and in other respects.

In December, a report was made to the Board of Trustees on progress the Committee had made to date in trying to determine if a medical director component was feasible. Some of the activities taking place were: a mail survey of all state medical associations and state licensing bodies was being conducted to determine if a program existed and to ascertain details; the tentative duties and responsibilities of a medical director were being defined; and funding sources were being identified. At a subsequent meeting of the Executive Committee of the Board of Trustees, a report was made that requested approval to invite the medical directors from other states to come and meet with the Committee in order to learn more about their individual programs.

To this end, representatives were sought from a state that was fully operational with a history of success; a state which had a full-time director and had only been operational for a relatively short time; a state with a medical director program that had failed; and a state that had, essentially, a total voluntary program. Representatives from these states were identified and invited to a meeting held at the KMA building in the middle of July. Also in attendance were representatives from the Board of Medical Licensure, members of the Board of Trustees, and Committee members. Considerable information was received and exchanged.

The next step that the Committee has identified is to

explore and try to tentatively secure stable funding sources for the program. Whether or not a medical director program will be established will be answered primarily if the Committee is able to resolve the questions of funding and work load, and these issues will be pursued with the full awareness and guidance of the Board of Trustees.

On behalf of the Committee, I would like to thank the Board of Trustees for its support and encouragement, as well as its close superintendance of KMA resources. I would also like to thank all of the Committee members for their many unacknowledged hours spent on behalf of the Association and the individuals we are organized to assist.

Burns M. Brady, MD
Chairman

Report of the Committee on Care for the Elderly

The Committee on Care for the Elderly had an active year. Many of its efforts were devoted to helping to develop and finalize the activities of the Kentucky Geriatrics Society, but continuing Committee activities consumed a good deal of effort.

Articles on geriatric treatment were submitted again this year for publication in the "Clinical Notes on Aging" section of the KMA *Journal*, and direct solicitation of articles continued.

Legislative activities caused a redirection of a good bit of the KMA resources, and the Committee followed legislation which specifically had impact on geriatric care. The Committee followed with interest the course of the living will bill and the parallel health surrogate legislation. The Committee has supported, as has KMA, this issue for the past two legislative sessions and was gratified to learn that a law now pertains. Other legislation of interest was a bill requiring the Insurance Commissioner to develop a consumer guide to long-term care and a bill that establishes the office of the long-term care ombudsman.

Previously, the Committee had developed and published an adult abuse brochure in conjunction with the Consumer Protection Division of the Attorney General's office. This year the brochure was updated and sent out to the membership, as well as to various state agencies and facilities for their use.

The Committee endorsed the Summer Series on Aging program conducted by the Sanders-Brown Center on Aging of the University of Kentucky, and assisted in publication activities. This course, which addresses current issues in geriatric medicine and care, has been held annually for seven years and constitutes an excellent series of educational activities for physicians, nursing personnel, and nursing home administrators.

Efforts were finalized this year to form the Kentucky Geriatrics Society (KGS). During the Annual Meeting last year, a hosted dinner was convened for persons potentially interested in becoming members of the Society, and plans were made to continue potential membership development. In November, another meeting was convened to define specific tasks for completing the Society's development, and a steering committee was appointed to fulfill task responsibilities. In March, a third meeting was conducted at which tentative bylaws were considered, goals and purposes of the Society were reviewed, discussions were held concerning nonprofit organizational status, and officers were nominated. In April, the Society made application to the Board of Trustees as a designated specialty group, and this request was approved.

The Society's purpose, as opposed to that of the Committee, will be primarily scientific and educational. Its membership will be open to anyone interested in geriatric care, but only physicians may be active members.

As a designated specialty group, the KGS has been allotted meeting time during the Annual Meeting, has solicited a speaker for the general session, and has arranged for a separate KGS scientific and business meeting. At this meeting, the bylaws will be formally adopted and initial officers elected.

The Committee is gratified with the development of the KGS, feeling it will serve an important role as the focal unit for individuals and organizations actively involved in the care of the elderly. Hopefully, it will serve, too, as a forum for the enhancement of knowledge and clinical experience in this aspect of medicine.

On behalf of the Committee, I would like to thank the KMA Board of Trustees for its support of the Committee's effotts, and I would like to thank the Committee members for all their work and input.

John C. Wright, II, MD
Chairman

Report of the Ad Hoc Committee on Professional Liability Insurance

Addendum to the Report of the Chairman, Board of Trustees

The Ad Hoc Committee on Professional Liability Insurance is directed by the Board of Trustees to review and study various proposals, including legislative relief through tort reform, peer review measures such as claims prevention, and recommendations to relieve the present crisis in liability insurance. The Committee representation includes various specialty groups, regional representation, KMA officers, and Trustees. Recommendations from this Committee are forwarded to the KMA Board of Trustees for approval and recommendation for action.

Although the full Committee did not meet this year, the

PLI Executive Committee convened on three separate occasions. Due to the fact that the House of Delegates had previously established a tort reform agenda and that the General Assembly met in 1990, it was not deemed necessary for the entire Committee to meet. The KMA program, as defined by the House, is as follows:

Primary recommendations include:

1. Constitutional amendment to permit the Kentucky General Assembly to cap noneconomic awards;
2. A No-Fault Approach to Medical Malpractice/A Patient Compensation Plan.

Secondary recommendations include:

1. Reduce Statute of Limitations for minors;
2. Mandate periodic payments of future damages in lieu of lump sum payments;
3. Adopt a Perinatal Neurological Impairment Compensation Program.

We refer members to the 1990 KMA Legislative Report, mailed with the June *Journal*, which outlines all bills relating to tort reform on pages 23-25. It would be redundant to outline those proposals in this report. However, the adoption of HB 553, which provides for full statutory protection of "qualified retirement plans" from judgment and, also, excludes "qualified retirement plans" from the estate in the event of bankruptcy, was a significant legislative victory. In addition, we are also pleased to report that we were successful in the passage of HB 657, which reenacted the confidentiality of peer review provision struck down in 1989 by the Kentucky Supreme Court in *Sweasy v King's Daughters Memorial Hospital.*

Two primary recommendations adopted by the House of Delegates were introduced, including SB 192, which calls for amending Section 54 of the Kentucky Constitution to allow the General Assembly to limit recovery in tort for noneconomic loss and to prescribe the manner in which damages shall be paid. Also, SCR 95, as introduced, directed the Legislative Research Commission (LRC) to appoint a task force to study alternative methods of dispute resolution and more efficient ways to deal with conflicts, including complex matters now dealt with only by our judicial system. Neither of these two proposals was adopted by the General Asembly.

The Committee was extremely impressed with a Kentucky Chamber of Commerce program called Kentucky Forward. The program, modeled after a North Carolina pilot project later utilized in several southeastern states, seeks to involve business, industry, and trade associations in a process of studying legislative districts and determining prevailing attitudes and policies. Once these studies are completed, the legislative voting records are compared with the district philosophies and attitudes. This information can then be utilized by associations and political action committees for determining their positions on legislative races. This program has been very successful in North Carolina and the Kentucky Chamber of Commerce raised over $70,000 for the project. The Committee adopted a motion to become a member of the coalition and staff has worked with Kentucky Forward to implement the program. In addition, Robert G. Cox, Executive Vice President of KMA, was a charter member of the Kentucky Forward Board, joining many top Kentucky business executives in managing the new program. During the 1988 Session of the Kentucky General Assembly, the Kentucky Chamber of Commerce staff worked on a daily basis with KMA staff, lobbying legislators and promoting the tort reform package to their members. The Committee is extremely grateful for the Chamber's continuing support of liability reform and its willingness to work with us on an ongoing basis.

Recognizing the continuing critical role that liability insurance plays in the practice of medicine and KMA's need to highlight the liability insurance and tort reform issues as public issues, it is important to maintain a positive program aimed toward eventual reform of the entire judicial system as it relates to professional liability. We note an increasing interest on the federal level, particularly by Congress, in forcing states to address the problem, recognizing that, to a large degree, dramatically rising health costs may be directly tied to the malpractice crisis. Even though the 1990 Kentucky General Assembly refused to adopt SB 192 and SCR 95, nonetheless we will continue to press for action on these two proposals. During the interim legislative period, we plan to keep the liability crisis before the public, the legislature, and the profession.

We made every effort to keep membership informed of our efforts in PLI and other legislative areas during the 1990 Session. We also conducted a legislative seminar in Frankfort for Key Contact physicians, specialty officers, and Auxiliary members involved in the legislative effort. The "Legislative Bulletin" was printed on a weekly basis and mailed to every member. In addition, we developed an exceptional "Legislative Handbook" and completed a final report of the Session, mailing both Handbook and report to every member. We plan continuance of these programs in 1992 to facilitate the continuation of our legislative, particularly tort reform, effort.

We thank the Board of Trustees for its guidance and especially appreciate the membership's strong support for aggressive action and support for professional liability reform.

Wally O. Montgomery, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Committee on State Legislative Activities

The Committee on State Legislative Activities met on three occasions during the Associational year. In addition,

the Quick Action Committee met in Frankfort on 15 occasions during the 1990 Session.

The 1990 KMA Legislative Report, printed and mailed with the June *Journal*, provides the bulk of the report of the Committee on State Legislative Activities. The agenda established by the KMA House of Delegates included over 35 directives. We are pleased to report that the General Assembly responded very favorably to our legislative program and adopted 24 KMA legislative proposals.

The following House of Delegates directives were adopted or supported by the 1990 Kentucky General Assembly:

- Reenacted confidentiality of peer review provisions. HB 657
- Developed monitoring system for managed care plans. HB 207
- Adopted all-terrain vehicle restrictions. SB 158
- Exempted pension plans from judgment. HB 553
- Supported respiratory therapist certification. SB 136
- Certificate of Need. SB 68
  Exempted physicians' offices from CON.
  Raised required CON thresholds.
  (KMA opposed CON exemption of Jefferson County hospitals.)
- Passed a requirement that signs in liquor establishments warn pregnant women not to consume alcohol. HB 115 ADOPTED-VETOED
- Prohibited children under 16 from purchasing tobacco. HB 628
- Supported health education at all school levels, K-12. HB 940
- Approved the living will bill. HB 113, SB 88
- Supported increased funding for prenatal/pediatric care. HB 799
- Enhanced AIDS reporting procedures. HB 425
- Prohibited discrimination of HIV positive patients. HB 425
- Supported release of medical information to health workers exposed to AIDS patients. HB 425
- Provided that consent for treatment by a physician or hospital shall also include the possibility of testing for HIV. HB 425
- Supported revision of Medical Practice Act. SB 246
- Supported criminal penalties for unauthorized removal of animals or damage of animal biomedical research laboratories. SB 175
- Supported expansion of the medical examiner system. HB 799
- Restricted prescription drugs by mail. HB 102
- Opposed mandatory health insurance benefits.
  The Kentucky General Assembly defeated HBs 450 and 631, and SB 221; however, HB 62, mandatory coverage for mammograms, and HB 626, mandatory coverage for TMJ, were adopted.
- Strengthened state's ability to regulate health insurance by adopting restrictions on peer review, specifically problems relating to preadmission certification. SB 246, HB 781.
- Opposed repeal of motorcycle helmet law. HB 490
- Opposed mandatory AIDS counseling. HB 165
- Opposed independent nurse practice, prescribing, etc. HB 86

The following House of Delegates directives were introduced but not adopted by the 1990 KGA:

- Authorize a constitutional amendment on the ballot to limit noneconomic awards. SB 192
- Study no-fault proposals to replace the present fault-based system. SCR 95
- Adopt legislation on advertising, disclosure policies, limitations, exclusions. HBs 52 and 53
- Institute school bus safety and inspection programs. HB 35, SBs 261 and 341
- Support reduction of BAC for drivers from 0.10 to 0.05. HBs 27 and 333, and SBs 163 and 183
- Mandate mandatory seat belts. HB 457
- Require periodic retesting of vision at drivers license renewal. SB 339
- Restrict minors from riding in rear of pick-up trucks. HBs 110 and 160
- Forbid tobacco use on school property. HB 127
- Raise cigarette taxes. HB 543
- Approve the KMA proposal on indigent care. SB 324
- Support repeal of mandatory chiropractic coverage. HB 450

We deeply regret that the General Assembly failed to enact more stringent penalties for drunken driving and school bus safety measures. However, both the Governor and General Assembly leadership indicate that these proposals may be agenda items for future special sessions. The only safety legislation bill to be enacted was KMA's recommendation that restrictions be required of all operators of all-terrain vehicles and that helmets be mandated. The late Senator John E. Trevey, MD, worked very dilligently for four years on this proposal and successfully achieved its passage in 1990.

The most controversial aspect of the 1990 Kentucky General Assembly was the adoption of SB 68, the Certificate of Need bill which exempted Jefferson County hospitals from its provisions. KMA had its hands full in preserving the physician's office exemption from CON and we were forced to defeat this measure on three separate occasions. However, there is recognitioin within the medical community that regional (especially urban) exemptions from the CON process give an unfair advantage over other areas.

At the final meeting of the Committee on State Legislative Activities, a lengthy discussion took place regarding KMA's position on Certificate of Need and the realization that this issue may again be a topic during the 1992 Session of the Kentucky General Assembly. KMA's present position, based

on the COSLA report adopted by the 1989 House of Delegates, is as follows:

> The KMA Committee on State Legislative Activities endorses the retention of the Certificate of Need law with an option of reviewing modifications as periodically proposed. The Committee supports the preservtion of the private physician's office exemption as it presently exists.

Recognizing that the physician community is torn between the free market concept and the growing crisis in health costs, the Committee proposed several recommendations to the KMA Executive Committee. These recommendations included highlighting the CON issue during the Annual Meeting at a special meeting of a Reference Committee and generally seeking members' input on this controversial matter. It was generally agreed that, from a public and legislative viewpoint, KMA's position is somewhat vague and may not truly reflect the majority of physicians' philosophical views.

Mandatory health benefits for specific illnesses, procedures, or providers under health insurance policies continue to be a major issue. According to most studies, mandated benefits are a major deterrent to reducing health costs in the US. Several years ago, the KMA House of Delegates adopted a Resolution calling on KMA to repeal mandatory chiropractic coverage under health insurance policies. Based on our legislative experience and discussion with legislators and other business groups, the Committee recommends that the KMA, in lieu of this specific repeal proposal, continue to seek exemption from present specific mandatory health insurance coverages and oppose any future provision which mandates individuals or groups to carry specific levels of coverage for providers' services. We support the concept that health insurance benefits and coverages should be based on the group's or individual's health insurance needs in accordance with their economic ability to pay.

During the 1990 Session, the Attorney General's office attempted to have a triplicate prescription bill introduced. The KMA, Kentucky Pharmacists Association, and other groups opposed the concept but agreed to study the problem during the interim and determine its effectiveness in reducing access to "legal" drugs on the streets. The Committee recommends a study of the triplicate prescription concept and other reasonable controls to address this problem and that a report of its findings be presented to the 1991 House of Delegates.

The Committee also discussed the issue of corporal punishment in schools. We have had numerous inquiries seeking KMA's support banning corporal punishment in schools. The AMA is on record opposing corporal punishment in schools. We recommend that the Board of Trustees refer this issue to an appropriate committee for study and that a report of its findings be presented to the 1991 House of Delegates.

The tragic and sudden death of Jack Trevey was a very personal loss to those of us who knew him. He enjoyed medicine and politics and was very successful in melding the two. Senator Trevey was a staunch and crafty advocate of the medical profession. Despite the fact that he moved in a highly political environment, he never forgot his physician roots. In the past 15 years he has been in the forefront of every battle in which medicine found itself. With the exception of his General Assembly colleagues, KMA staff, and physicians knowledgeable in the legislative arena, it is virtually impossible to measure the loss of the guidance, strategy, and just plain common sense he provided to KMA's legislative program. We will remember him as a colleague and friend whose contributions to patients, his profession, and the Commonwealth provide a legacy to which we can all aspire. The tandem of Jack Trevey and Nick Kafoglis, two physician/politicians who enjoyed widespread respect and popularity within the General Assembly, provided medicine with the most effective voice for quality care in the US. It is unlikely it will ever be duplicated.

On behalf of members of the Committee and staff, we appreciate the support you have provided us. The legislative program at KMA is viewed as a major priority by the members of the Board of Trustees and their collective and individual efforts in working with leadership and staff have been exemplary. The Board has supported your call for strong legislative involvement and we believe the outstanding Session achieved in 1990 is indicative of that goal.

Wally O. Montgomery, MD
Chairman

RECOMMENDATIONS:

1. The Committee on State Legislative Activities recommends that the Board of Trustees refer the issue of corporal punishment in schools to an appropriate committee for study and that a report of its findings be presented to the 1991 House of Delegates.
2. The Committee on State Legislative Activities recommends that KMA, in lieu of separate repeal of mandatory chiropractic coverage under health insurance policies, continue to seek exemption from present specific mandatory health insurance coverages and oppose any future provision which mandates individuals or groups to carry specific levels of coverage or providers' services. The Committee supports the concept that health insurance benefits and coverages should be based on the group's or individual's health insurance needs in accordance with their economic ability to pay.
3. The Committee on State Legislative Activities recommends a study of the triplicate prescription concept and other reasonable controls to address access

to legal drugs on the streets and that a report of these findings be presented to the 1991 House of Delegates.

Resolution O

Centralized Database for All Prescribed Medications and Drugs in the Commonwealth of Kentucky
Hardin-LaRue County Medical Society

WHEREAS, physician members of the Hardin-LaRue County Medical Society have had occasion to treat individuals who are taking prescribed medications unknown to the physician, and

WHEREAS, physicians have seen and evaluated patients who were taking prescribed medications causing untoward drug interactions, and

WHEREAS, physicians have seen and evaluated patients who are taking narcotic analgesics, and the patient seeks an additional prescription from another physician for the same or similar narcotic analgesic agent, now therefore be it

RESOLVED, that the Kentucky Medical Association supports legislation establishing a centralized database for all prescribed drugs or medications in the Commonwealth of Kentucky for easy access by physicians and pharmacists in the Commonwealth.

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed the Report of the Committee on State Legislative Activities and its Recommendations. The Reference Committee commends Wally O. Montgomery, MD, and extends its appreciation to him for all the work he has done on behalf of the Committee on State Legislative Activities. Reference Committee No. 3 recommends the adoption of the Report of the Committee on State Legislative Activities and Recommendations 1 and 2.

Reference Committee No. 3 next reviewed Resolution O, Centralized Database for All Prescribed Medications and Drugs in the Commonwealth of Kentucky, submitted by the Hardin-LaRue County Medical Society.

The Reference Committee recommends the "Resolved" portion of Resolution O be amended by deleting the words "supports legislation establishing" and inserting the words "study the establishment of." The "Resolved" would then read as follows:

> "RESOLVED, that the Kentucky Medical Association ~~supports legislation establishing~~ study the establishment of a centralized database for all prescribed drugs or medications in the Commonwealth of Kentucky for easy access by physicians and pharmacists in the Commonwealth."

In lieu of Recommendation 3 of the Committee on State Legislative Activities, Reference Committee No. 3 recommends the adoption of Resolution O as amended.

Resolution F

Living Wills/Health Care Surrogates
Fayette County Medical Society

WHEREAS, the Kentucky Medical Association endorsed living will and health care surrogate legislation, and

WHEREAS, living will and health care surrogate legislation was adopted by the 1990 Kentucky General Assembly, now therefore be it

RESOLVED, that the Kentucky Medical Association work with the Kentucky Bar Association to develop a model living will and health care surrogate document, and be it further

RESOLVED, that the KMA print the model living will and health care surrogate documents and distribute them at cost to physicians, and be it further

RESOLVED, that the KMA encourage Kentucky physicians to have these living wills and health care surrogate documents available for their patients, and be it further

RESOLVED, that KMA develop posters for display in physicians' offices and public service announcements indicating that living wills and health care surrogate documents are available.

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed Resolution F, Living Wills/Health Care Surrogate, introduced by the Fayette County Medical Society, and recommends the second "Resolved" be revised by inserting after "surrogate documents" the phrase "and appropriate informational materials." The Reference Committee also recommends the deletion of the last "Resolved." The "Resolved" portion of Resolution F would then read as follows:

> **"RESOLVED, that the Kentucky Medical Assocaition work with the Kentucky Bar Association to develop a model living will and health care surrogate document, and be it further**
>
> **RESOLVED, that the KMA print the model living will and health care surrogate documents <u>and appropriate informational materials</u> and distribute them at cost to physicians, and be it further,**
>
> **RESOLVED, that the KMA encourage Kentucky physicians to have these living wills and health care surrogate documents available for their patients."**

Reference Committee No. 3 recommends the adoption of Resolution F as amended.

Resolution M

Physician Candidates for Public Office and Third-Party Positions
Jefferson County Medical Society

WHEREAS, better informed and more active citizens will result in better legislators, better government, and better health care, and

WHEREAS, support of qualified physician candidates for public office and third-party insurance policy-setting positions is to the benefit of the enlightened self-interest of the medical profession, and

WHEREAS, the tragic and sudden death of Kentucky Senator Jack Trevey, MD, underscores the deep sense of loss of one of Kentucky's two legislative physician advocates of the medical profession, now therefore be it

RESOLVED, that the Kentucky Medical Association and all Kentucky physicians be encouraged to actively solicit physicians to run for public office and seek policy-setting positions with third-party payors and insurors.

Recommendations, Reference Committee 3:

Reference Committee No. 3 reviewed Resolution M, Physician Candidates for Public Office and Third-Party Positions, introduced by Jefferson County Medical Society. Reference Committee No. 3 recommends that Resolution M be adopted.

Resolution D

Certificate of Need
Board of Trustees

WHEREAS, the 1990 Kentucky General Assembly granted Jefferson County hospitals exemption from the Certificate of Need process, and

WHEREAS, regional and local exemptions to the Certificate of Need process are discriminatory and represent special legislation, and

WHEREAS, special exemptions granted by the General Assembly may lead to a concentration of medical care in urban areas, which may ultimately deprive rural Kentuckians of health insurance options and access to medical care, now therefore be it

RESOLVED, that the House of Delegates reaffirm the recommendation adopted by the 1989 KMA Committee on State Legislative Activities which endorsed the retention of the Certificate of Need law with an option of reviewing modifications as periodically proposed. In addition, KMA continues to support the preservation of the private physician's office exemption as it presently exists, and be it further

RESOLVED, that the KMA continue to oppose exemptions based on geography, population, and number of acute hospital beds, and that it urge the repeal of those exemptions granted to Jefferson County hospitals by the 1990 Kentucky General Assembly.

Reference Committee No. 3 met in special session to consider Resolution D, Certificate of Need, introduced by the Board of Trustees. The Reference Committee heard extensive discussion on the issue of Certificate of Need from a number of Delegates as well as other interested parties. There was general agreement with the proposed Resolution; however, the structure of the Resolution was amended to incorporate three "Resolveds" instead of the initial two. The Reference Committee also recommended deleting the word "urge" in the third "Resolved" and substituting the word "support." The entire "Resolved" portion of Resolution D would then read as follows:

"RESOLVED, that the House of Delegates reaffirm the recommendation adopted by the 1989 KMA Committee on State Legislative Activities which endorsed the retention of the Certificate of Need law with an option of reviewing modifications as periodically proposed. ~~In addition,~~ and be it further

RESOLVED, that the KMA continue to support the preservtion of the private physician's office exemption as it presently exists, and be it further

RESOLVED, that the KMA continue to oppose exemptions based on geography, population, and number of acute hospital beds, and that it ~~urge~~ support the repeal of those exemptions granted to Jefferson County hospitals by the 1990 Kentucky General Assembly."

Reference Committee No. 3 recommends the adoption of Resolution D as amended.

Mr Speaker, Reference Committee No. 3 recommends the adoption of the Report of Reference Committee No. 3 as a whole.

Mr Speaker, I wish to thank the members of Reference Committee No. 3 for their participation and patience in the review of these important issues and the formulation of policy in these matters. Members of the Committee are Donald E. Brown, MD, Somerset; Samuel G. Eubanks, Jr, MD, Louisville; John T. Houston, MD, Owensboro; and Scott B. Scutchfield, MD, Danville. I would also like to thank Jeanette Thompson for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 3

John D. Stewart, MD, Lexington, Chairman
Donald E. Brown, MD, Somerset
Samuel G. Eubanks, Jr, MD, Louisville
John T. Houston, MD, Owensboro
Scott B. Scutchfield, MD, Danville

Report of the Chairman KEMPAC Board of Directors

Mr Speaker, Fellow Delegates:

It is a pleasure for me, as Chairman of the KEMPAC Board of Directors, to give you a report of KEMPAC activities for this past year.

Appointed by the KMA Board of Trustees, KEMPAC supports candidates who share our philosophy and concerns with regard to legislation that affects the Medical profession and *quality patient care.* We win friends during political cam-

paigns by helping in many ways. When our *Views* are made known to a candidate, along with *Financial Support* and *Volunteer Work* during their campaign, it is remembered after they take office.

We are pleased to announce that due to your support this year, KEMPAC contributed over $40,000 to State candidates in the Primary and General Election. This money was contributed early in the Primary and additional funds have been provided to candidates in the General Election. We were able to give substantial support to *Key* Legislative races. Support for the U.S. Senatorial race, Congressional and State races were decided upon at the Board of Director's meeting Tuesday morning, September 25.

On the National level, at KEMPAC'S request, AMPAC has contributed in excess of $31,000 to Kentucky candidates for the U.S. House. Together, KEMPAC and AMPAC were able to contribute over $71,000 to candidates in the Primary and General Election this year.

I must emphasize that although KEMPAC-AMPAC funds are given in the name of Kentucky physicians, your individual support as a physician on the *local* level is very important, if not the most important factor.

Our membership goal for 1990 was 900. Our current membership is 734. In August, a membership promotion letter was circulated encouraging doctors who had not contributed to KEMPAC for 1990 to better support the candidates of this election year to be able to do so. We have, so far, received a very positive response. The KEMPAC Board of Directors recommends that you reaffirm and include the billing of KEMPAC-AMPAC dues in the statewide billing of 1991 KMA dues.

In June of this year, Fay Miles retired after 23 years as KEMPAC Executive Director. I would like to introduce Vicki Thorpe who replaced Fay. Vicki has been with us since May and has quickly been introduced to the inner workings of KEMPAC.

On behalf of the KEMPAC Board, I want to thank you delegates and the KMA Board of Trustees for your continued support.

Thank You.

David B. Stevens, MD

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 4

David W. Douglas, MD, London, Chairman

28. Report of the Committee on Medical Insurance and Prepayment Plans
29. Report of the Committee on Claims and Utilization Review
30. Report of the PRO Advisory Committee
31. Report of the Committee to Investigate Changing Trends in Medicine
5. Report of the Chairman, Board of Trustees, Report of the Ad Hoc Committee on Quality of Care, **only**

Resolution E — Inequitable Reimbursement (Oris Aaron, MD, Columbia)

Resolution T — Sentinel Medical Review Organization (Floyd County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 4 reviewed the following items and recommends they be filed by consent of the House without discussion:

29. Report of the Committee on Claims and Utilization Review — filed
30. Report of the PRO Advisory Committee — filed

Mr. Speaker, Reference Committee No. 4 recommends adoption of the Consent Calendar as a whole.

Report of the Committee on Claims and Utilization Review

The Committee on Claims and Utilization Review met this year and considered a number of cases which were indicative of the changing nature of insurance coverage amid the proliferation of managed care plans.

In recent years, claims volume has dwindled significantly because most insurance coverage currently appears to be very closely defined. With the increased presence of managed care plans, coupled with restrictions placed on more conventional insurance coverage, fee questions are rare. Insurance coverage, as opposed to actual medical necessity, however, stands as a crucial issue. Of the cases reviewed, nearly all had two questions at the core: (1) even though coverage did not apply in strict terms, was the treatment medically necessary, and (2) would the carrier or plan manager reimburse for the care beyond the limits of coverage.

In this event, it occurred that most cases did portray true medical necessity. It is likely that the carrier will reimburse for the noncovered services on this basis. However, the obvious question arises as to how many situations of this nature occur that never receive medical review. Similar cases did not reach the Committee for review because of negotiated settlement.

A notable point that developed from these episodes is that physicians are increasingly required to be familiar with coverage provisions prior to treatment in the interest of patients. The provision of needed, appropriate care should, of

course, not be contingent on insurance coverage, but the provision of noncovered care ultimately becomes a financial liability to the patient, the physician, and facilities.

The increasing responsibility of the physician for involvement with insurance coverage provisions is unwanted and perhaps unwarranted, but is a fact of medical practice today. Regardless of seemingly onerous influences of insurance coverage, physicians must serve as the patient's advocate, not only through the provision of care, but as a representative to insurance companies. While it is not reasonable that the physician should become a *de facto* insurance agent, it is likewise unreasonable for physicians to be disassociated with the necessary transactions required from managed care plans. In this context, however, physicians are encouraged to bring such questions to the peer review system, which is an advocate for physicians.

Although claims volume has dwindled as it affects district committees, the efforts of these groups should not go unrecognized, and the membership owes these individuals a debt of thanks for their efforts.

K. Thomas Reichard, MD
Chairman

Report of the PRO Advisory Committee

The PRO Advisory Committee is charged with monitoring professional peer review organization (PRO) developments, providing a forum for discussions of PRO activities, and serving as a physician's advocate to the PRO, Sentinel Medical Review Organization.

At the beginning of the year, a number of complaints were received from members concerning inequitable review and a lack of access to reviewers of Medicare hospital admission episodes. An initial meeting was held with representatives of Sentinel, and it was noted that in some instances it appeared that reviewers may not be appropriately checking medical records in sufficient detail.

The Committee was advised that cases for review were selected on a random sample basis (excluding a requirement for 100% review for certain procedures). These cases then undergo generic screens; ie, for a given diagnosis, certain procedures were assumed to be necessary, and should be performed.

If these cases do not pass generic screens, they are referred to a physician reviewer. An attempt is made to match specialties, but this is not always possible because of a dearth of reviewers. If the physician reviewer finds a discrepancy, a letter is sent to the attending physician and it is at this point some misunderstanding has developed, particularly in the area of "quality determinations." The PRO is required to indicate the level of quality being questioned, and it was learned that less than 20% of these initial letters are answered by the attending physician.

If there is no response from the attending physician, a case is then referred to a second physician reviewer of the same specialty. If the second reviewer cannot resolve the case, the matter may be sent to the Quality Assurance Committee or, if the situation is severe enough, to a Sanction Committee for consideration of a sanction.

In the quality determination process, there are three sanction levels: Level I generally involves an error in documentation; Level II includes instances where there is potential for harm to the patient; and Level III is where harm actually occurs to the patient. One quality point is assigned for Level I, five points for Level II, and 25 points for Level III. These points are stricken each quarter, and no action is taken unless 25 points are attained in any given reporting period. Physician reviewers are not required to identify themselves to the attending physician, although they may do so if they choose, and this had caused some concern among Committee members.

On the basis of concerns voiced by the Committee, the Sentinel representatives agreed to conduct an educational program for physician reviewers to make them more aware of the concerns of practicing physicians and to give more careful scrutiny to medical records. It was agreed to review letters sent to attending physicians to ameliorate what some considered to be inflammatory language. Sentinel was also requested to provide further information to the Committee on the sanction process and noted the ongoing problem Sentinel had with acquiring an adequate number of physician reviewers.

In a subsequent meeting, it was learned that Sentinel had undergone some personnel changes and, as a result, a new Medical Director had been appointed. Other internal changes had taken place to streamline the review process, which included closer monitoring of physician reviewers. The enhanced review process was discussed, and the Committee made some suggestions which were accepted for consideration. More thorough and accurate review at the beginning of the review process was encouraged, and Sentinel agreed to try to effect further changes. Also, specific problems of individual members were addressed.

From the standpoint of the PRO, Sentinel again indicated its need for more physician reviewers and noted that physicians should respond to all inquiries.

At this meeting, representatives of the Jefferson County Medical Society were invited to express some specific concerns they had experienced, and these concerns were addressed.

Through the forum of two regular meetings and a number of other informal meetings, it was the Committee's opinion that communication is a considerable problem. While some of Sentinel's activities are not well understood by many physicians, many physicians do not respond to inquiry letters or respond beyond an initial 30-day requirement period. Because of an initial inadequacy in the number of physician

reviewers, some instances of review occurred that were not adequate to a given case. Since the beginning of the year, this situation has improved.

Initially, Sentinel was forced to contend with a considerable backlog of cases inherited from the previous PRO, and this administrative burden resulted in review errors, as well as a considerable length of time between the occurrence of the services and final review analysis. Personnel changes and reorganization have resulted in improved operations and better communication, and it is hoped that this trend will continue. In addition, Sentinel is seeking to expand its medical review operation further by acquiring more salaried physician personnel.

The Committee found the Sentinel representatives to be open and understanding regarding concerns of practicing physicians and willing to work with the Committee to all reasonable ends. As Chairman, I would like to thank the members of the Committee for their efforts and the representatives with Sentinel Medical Review Organization for their cooperation. In the coming year, the Committee intends to continue serving as an advocate for physicians and will continue its discussions with Sentinel on issues of mutual concern.

James M. Bowles, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Committee on Medical Insurance and Prepayment Plans

The Committee on Medical Insurance and Prepayment Plans met on two occasions this year, November 29, 1989, and July 11, 1990.

The mission of the Committee is to hear problems and plans of third-party carriers, serve as primary liaison with carriers for KMA, and speak on behalf of KMA to address problems or suggestions the Association might have.

Resolution Q — Reimbursement for Child Psychiatric Diagnoses — 1989 House of Delegates

Resolution Q asked that the appropriate committee of KMA study the problem of exclusion of insurance reimbursement for certain categories of child psychiatric diagnoses and make recommendations with regard to requirements for coverage under third-party insurance policies written in Kentucky. Resolution Q was not adopted by the House but was referred to the Board of Trustees for more information. Our Committee was asked to meet with the author of Resolution Q to obtain more information and advise the Board as to what action the Committee felt was appropriate.

The Committee met with representatives of the Kentucky Psychiatric Association (KPA). The KPA was concerned that many child psychiatric disorders are not covered by insurance. One example given was Attention Deficit Hyperactivity Disorders.

The Committee noted that while it was sympathetic to the concerns brought forth in Resolution Q, today, insurance plans contain those benefits that the employer and/or individual is willing to pay for. In discussion with various carriers, the Committee has learned that most employers do not add this coverage due to the expense involved and the inability of most carriers and providers to control utilization. In addition, the long-standing policy of the KMA House of Delegates is one of opposition to mandated benefits of any kind.

The Committee suggested that the Kentucky Psychiatric Association gather data on specific illnesses to demonstrate the value of various therapies. That data could then be presented to carriers to demonstrate the efficacy of the treatments rendered. The KMA Board supported these recommendations.

HMO Kentucky/Option 2000+ — Kentucky Blue Cross and Blue Shield

One of the major roles of this Committee is to meet with carriers to discuss products being made available in Kentucky and to provide physician input to the extent possible in their development.

Kentucky Blue Cross and Blue Shield has been faithful in making an effort to maintain dialogue with organized medicine, which the Committee very much appreciates. Kentucky Blue Cross and Blue Shield is still the largest carrier in the state, and, as such, its operation affects almost every physician.

In mid-July, the Committee met with representatives of Blue Cross and Blue Shield who presented their plans for restructuring the HMO Kentucky and Option 2000 products. Plans are for the Option 2000 program to be marketed on a statewide basis and for the HMO product to be introduced into metropolitan areas in the fall.

The new plan will have some significant changes. There will be one contract which will apply to both plans but will have separate attachments, allowing a physician to sign up for either Option 2000 or HMO Kentucky, or both. HMO Kentucky will do away with its capitation reimbursement and move to a set fee schedule. The same fee schedule will be available to those physicians participating in Option 2000. The Committee has not seen the fee schedule but understands that it will be made available to physicians during the application process. There will be no withholds from physicians in either plan.

Blue Cross and Blue Shield shared copies of the new agreement and attachments with the Committee and answered questions for almost three hours. The Committee made a number of suggestions which it felt would make the

plan better and more readily acceptable to most physicians. Because of the length of the contract and its effect on so many physicians, the Committee recommended that KMA have the contract analyzed by legal counsel and make that analysis available to any member on request. The Committee notes that while some parts of the Blue Shield contract are distasteful, similar language will be found in almost all third-party contracts in effect today. The Committee would strongly encourage physicians to read any third-party contract and related material carefully before signing.

We are appreciative to Blue Cross and Blue Shield for giving KMA the courtesy of being informed early on about these changes and for the opportunity to comment and make suggestions.

Kentucky Kare — State Employee Health Plan

Two years ago, the state of Kentucky adopted a self-insured plan, called Kentucky Kare, as a health plan option for state employees. The Committee was pleased to have representatives from the Department of Personnel provide the Committee with a brief report on the status of the plan after its first year of operation.

The contract with the plan administrator, ICH of Louisville, will expire in November 1990. Requests for proposals were sent out in early spring of 1990. It was reported that Kentucky Kare has 102 hospitals under contract to provide care to state employees on a discounted basis. ICH has 79 full-time employees processing about 2,000 claims a week. After one year of experience, Kentucky Kare had almost 58,000 contracts representing 89,000 individuals.

The Committee has not received complaints from the membership regarding this plan and will monitor its continuing operation as new contracts are developed in late 1990.

Self-Insured Plans

One of the significant issues discussed by the Committee this year concerns the so-called self-insured plans. This type plan is becoming more popular in light of the increasing cost of prepaid insurance coverage plans.

In self-insured plans, employers assume the risk of providing the necessary funds to pay for employee medical costs. Payment of claims is usually handled by a third-party administrator providing administrative services only.

These plans have grown in popularity due to passage of the 1974 Employee Retirement and Income Security Act (ERISA) and certain IRS regulations. Section 514 of ERISA exempts self-funded employee welfare benefit plans from applicable state insurance laws. This exemption offers a number of incentives for a firm to self-insure:

Self-insured plans are not subject to state premium taxes. Such taxes may amount to significant numbers of dollars in increased insurance premiums to major corporations.

Self-insured plans are exempt from state-mandated benefit laws.

Individual self-insured plans are exempt from state laws regarding solvency requirements of insurors.

Self-insured companies are exempt from participation in state risk pools.

Self-insured employers achieve additional cost savings because they can retain and earn income on plan funds until claims are paid instead of paying premiums in advance to an insuror.

Based on these incentives and the increasing cost of insurance premiums, more companies are self-insuring. According to the Kentucky Department of Insurance, 1,500 plans in Kentucky have filed as self-insured plans, although the Department estimates that there are probably two or three times as many self-insured plans in existence in the state. In Kentucky, a self-insured plan is required to send the Department a $50 filing fee and arrange to have a conversion contract.

The Kentucky Department of Insurance has no other regulatory authority over self-insured plans. The US Department of Labor administers Title I of ERISA which provides certain minimum standards that employee welfare benefit plans must meet. These requirements relate to reporting and disclosure, fiduciary responsibility, claims procedures, and continuing health care coverage.

According to the Department of Labor, Title I of ERISA does not contain any requirements or standards relating to the maintenance of funding or reserve levels for welfare benefit plans. Title I of ERISA generally preempts any state law which "relates to" an employee benefit plan covered by Title I of ERISA.

There has been an increase in the failure of self-insured plans because most companies do not have the funds necessary to pay for unanticipated catastrophic illnesses. One such illness can bankrupt a small company, leaving employees with no coverage and providers with unpaid claims for services rendered. The Committee was concerned with this trend and felt that efforts should be made to address the issue.

After considerable investigation and research, including correspondence with the US Department of Labor and the Kentucky Department of Insurance, we felt that the most appropriate measure would be to support legislation to initiate changes in the ERISA law and IRS regulations. That would have to take place at the federal level.

The Committee recommended, and the Board approved, that a Resolution be introduced into the AMA House of Delegates this past June calling for the AMA to introduce and actively support legislation that would require self-insured health plans to be subject to the authority of state insurance law and regulations. That Resolution was introduced and reaffirmed existing AMA policy.

The problems of self-insured plans are becoming more

visible nationally which hopefully will give Congress the incentive to act soon.

Determination of Medical Necessity by Carriers

Members of the Committee reported that carriers are disallowing claims for services based on their determination that the services were not medically necessary. As a result, the Committee asked the Executive Committee to seek a determination as to what entities have the authority and responsibility to determine medical necessity. That inquiry was being initiated at the time of the writing of this report.

Minimum Benefits of Insurance and Managed Care Plans

Last year the House approved an excellent report from the Subcommittee on Minimum Benefits of Insurance and Managed Care Plans. That Subcommittee's report was a result of a year-long effort to develop information that could be shared with patients concerning minimum benefits that should be a part of any insurance plan, as well as questions patients should ask about insurance plans.

This information has been sent to KMA members six times through the *KMA Journal* and was included as inserts in the "Communicator" on two occasions. We strongly encourage physicians to copy this material and make it available to patients. This information was sent to 140 other organizations with the suggestion that these organizations share that information with their membership.

When the information was first released, it generated a number of inquiries from the news media. We are hopeful that this wide distribution and attendant publicity helped make many more people aware of what they should look for when purchasing health plans.

The Committee covered a great many issues in the span of two meetings. In addition to the issues discussed above, the Committee also discussed the experience of the KMA-endorsed Blue Cross and Blue Shield group health plan for the membership. We are happy to report that KMA had good claims experience in 1989 which resulted in a 10% rate increase in our plan. That, according to Blue Shield, was one of the lowest rate increases they delivered last year.

Because of the increase in premiums for the Blue Cross and Blue Shield KMA group plan over the past several years, the Committee asked for, and received, permission from the House three years ago to offer one option to the membership which contained the Blue Cross and Blue Shield Assurance Plus program. Assurance Plus includes preadmission certification, mandatory ambulatory surgery for certain procedures, second opinions, and other so-called cost containment features.

While our first year's experience was inconclusive, experience in the second year indicated that the Assurance Plus feature may have had some benefit. As a result, Assurance Plus was added to both plans last year. Because of the low rate of increase reported above, the Committee is of the opinion that Assurance Plus does have some positive effect on the premiums charged to our members. The Committee is not aware of any complaints received from the membership as a result of adding preadmission certification to the plan.

The Committee believes that Assurance Plus should be continued in subsequent renewals of the KMA plan until such time that there is conclusive evidence that Assurance Plus does not have a positive effect on claims experience and, therefore, premium rates.

The existing House of Delegates' policy is one of opposition to preadmission certification. In light of the effect that Assurance Plus, which contains a preadmission certification requirement, has had on our experience, the Committee recommends that KMA's policy of opposition to preadmission certification be changed to one of no position.

As Chairman, I appreciate the significant time, effort, and contributions made by the members of the Committee. These individuals work very hard on issues that have far-reaching implications on all physicians in Kentucky.

In addition, I appreciate the continuing cooperation and communication that we receive from Kentucky Blue Cross and Blue Shield and the Kentucky Department of Insurance.

Earl P. Oliver, MD
Chairman

RECOMMENDATION:

1. The Committee on Medical Insurance and Prepayment Plans recommends that KMA's policy of opposition to preadmission certification be changed to one of no position.

Recommendations, Reference Committee 4:

Reference Committee No. 4 would like to commend the Committee on Medical Insurance and Prepayment Plans on its excellent and thorough efforts on issues presented in its report.

The Reference Committee recommends that Report No. 28 and its recommendation be adopted.

Report of the Committee to Investigate Changing Trends in Medicine

The Committee to Investigate Changing Trends in Medicine held two meetings this year, January 17, 1990, and May 10, 1990.

The charge to the Committee is to study and report on evolving delivery and payment mechanisms; to study and report on demographic trends affecting medical practice; to study and report on ethical questions regarding financial

considerations versus quality of life; to investigate trends in cost containment activities; and to determine, to the extent feasible, the role of organized medicine in this changing environment.

Over the years, the Committee has looked into and reported on many issues, including the growth of nontraditional payment systems; various cost containment issues; the future physician population; the nursing shortage; physician advertising; the changing demographics of Kentucky; and our aging society.

Medical School Demographics

This year, the Committee devoted one entire meeting to the changing demographics that will affect the physician population of the future. Recent reports indicate that fewer qualified people are choosing medicine as a career and that today's applicants are less qualified than their predecessors.

There are now 126 US medical schools compared to 81 in 1960. In 1960, 54,000 medical students were enrolled in US schools, growing to a peak of 67,500 in 1984. Enrollment for the 1988-89 year totalled 65,000. In the 1988-89 academic year, there were 26,700 applicants for the 16,781 first-year medical school positions available. The highest number of medical school applicants occurred in 1977-78 when 40,000 people applied for medical school.

The 1988-89 applicant mix was 38% female (compared to 9% in 1969), 48% white male, and 14% minority males. Of those who applied to medical school in 1988-89, 60.5% were accepted compared to 40% in 1977-78. Females accounted for 37% of the entering classes in 1988-89, 35.1% of the total medical school enrollment nationwide, and 33.3% of the expected 15,646 MD graduates in 1990. However, despite the growing percentage of applicants that are female, the actual number of females who apply for medical school has declined since 1985-86, according to *JAMA*'s "89th Annual Report on Medical Education in the United States."

While the number of applicants has decreased in recent years, schools have been able to fill available first-year positions with qualified students. However, AMA Board of Trustees Report P, I-89, "Updated Projections of Physician Supply," states that the number of new US medical school graduates entering the active physician population is expected to decrease by 125 per year for a 10-year period, then remain constant. The number of entering foreign medical graduates (FMGs) with US citizenship is expected to fall from 946 to 500 per year between 1989 and 1994. The number of FMGs without US citizenship is expected to remain constant at 1,300 per year.

Report P states that despite the anticipated reduction in the number of US medical graduates, the total US physician population will continue to grow until the year 2000, due to the large training capacity of US medical schools that occurred during the period of growth in the '70s and early '80s. Thus, the US physician population is expected to increase by 19.6% between 1987 and 2000. The number of active physicians per 100,000 US population is expected to rise from 219.7 in 1987 to 238.8 in 2000. The projected rate of growth in the physician population is substantially higher than that of the US population as a whole.

The AMA Report concluded that the decline in medical school enrollments will not jeopardize the ability of the nation's health care system to provide adequate care to the US population.

The Committee was also concerned with the quality of today's applicant. Does the decline in the number of applicants mean that less qualified people will be accepted into medical school and that tomorrow's graduates will be less qualified and well trained than today's? And why are fewer applicants considering medical school?

Michael Foster, MD, Assistant Dean of Admission, University of Louisville School of Medicine; Jayne Middleton, EdD, Associate Dean for Education, University of Kentucky College of Medicine; and Linda Bratcher, Assistant Director of Admissions Programs, University of Louisville School of Medicine, met with the Trends Committee to provide a Kentucky-specific perspective. We appreciated the valuable information they shared with us. Kentucky's two schools are also experiencing a decline in applicants.

Nationally, average MCAT scores declined from 9.0 in 1984 to 8.7 in 1988. Grade Point Averages (GPAs) declined from 3.51 to 3.42 during the same period. University of Louisville entering students had an average MCAT of 8.83 in 1984, changing to 8.33 in 1989. GPAs changed from 3.56 to 3.45 in the same period. University of Kentucky entering students had an average MCAT of 8.8 in 1984, changing to 8.5 in 1989. GPAs changed from 3.63 to 3.38 in the same period.

Test results, such as MCAT, are an imperfect measure of the aptitude of an individual for a medical education or medical career, as are GPAs. While both measures have declined in Kentucky, the standards for promotion and graduation at both Kentucky schools have not changed.

Kentucky is in line with national trends regarding female students. The percentage of female medical students has grown from 31% to 39% in the period from 1984-89 at the University of Kentucky, and from 36% to 40% during the same period at the University of Louisville. Enrollment of minorities has been less successful at both schools.

Declines in the number of applicants as well as withdrawal and academic failure rates seem to be increasing at Kentucky's schools and are cause for concern. Several reasons were offered. High schools are not adequately preparing students for undergraduate and graduate school. Some students have withdrawn citing the heavy academic work load and conflicts with family over the life-style required of medical students. Others are simply unwilling to make the necessary commitment to school.

The cost of medical education can become overwhelming. The average debt at graduation at the University of Louis-

ville is $35,000 and $30,000 at the University of Kentucky. According to the American Association of Medical Colleges, in 1988, 83.4% of all medical graduates have an average total educational indebtedness of $38,489. Of those with debt, 24% have a total educational debt of over $50,000. Monthly student loan payments of $500 to $700 for resident physicians are not uncommon on typical monthly salaries of $2,200 to $2,300 in programs that are often located in urban areas with high costs of living. This problem is exacerbated by a provision included in the Omnibus Reconciliation Act of 1989 (PL 101-239) which takes away the ability of some resident physicians to defer repayment of their Stafford Student Loans beyond a two-year period.

The length of the medical education process is a problem. It is not uncommon for specialization to require 4-10 years following graduation from medical school. Other postgraduate opportunities and career paths offer equal or perceived superior rewards over a much shorter time frame. There is an apparent negativism among practicing physicians and college premed advisors. Their advice is to find something else to do. A recent AMA survey by the Council on Long Range Planning and Development found that 25% of the practicing physicians interviewed said they would probably not go to medical school if they could start all over again, and 14% said they definitely would not choose medical school. However, the majority of physician respondents felt positive about medicine as a career, found being a doctor rewarding, and liked their job.

Other reasons cited for not selecting medicine as a career included the feeling that government and third-party payor regulations interfere with the ability to practice medicine; lack of autonomy; too much administrative work; malpractice suits and medical-legal issues; too much pressure and stress; and a lack of respect by patients and others.

In summary, we conclude that there will be adequate numbers of physicians to care for the US population. Distribution of physicians will probably remain a problem. Fewer qualified individuals are choosing medicine as a profession, and the dilemma educators and society face is how to maintain standards of excellence while making medicine a more attractive career choice.

What is being done? What can be done? Both Kentucky medical schools are increasing their efforts to communicate with students as young as elementary age, with strong recruitment taking place at the 12th grade level. Medical school faculty could make presentations about the positives of a medical career. Communications should increase between medical faculty/admissions departments and college faculty advisors. New ways of communicating with high school and college students should be explored. Videotapes and fact kits could be developed and medical students and residents could participate in high school and college career days. Premedical courses could be extended to high school students.

Obviously these solutions require far more resources than KMA or the universities have available. The Committee feels there is an opportunity for KMA and the medical schools to work together to address this issue and are hopeful the Physician Manpower Committee might discuss more specific ways to meet this challenge.

HMO Development and Penetration In Kentucky

Nationally and locally, the rate of growth in HMOs is slowing and in some cases decreasing. Nationally, HMOs expanded their enrollment from the end of 1988 through the first six months of 1989 by only 1%.

The HMO industry continues its consolidation, with some plans closing and others being acquired by larger plans. The Committee reviewed statistics on Kentucky's HMOs provided by the Kentucky Department of Insurance. In 1986, 15 HMOs were active Kentucky. In 1989, there were 11 active plans owned by 5 companies. That number will be reduced when Kentucky Blue Cross and Blue Shield finalizes its purchase of Partners Health Plan.

In Kentucky, HMO enrollment in December 1986 totalled 393,942. In September 1989, the Department of Insurance reported enrollment totalling 600,913. Enrollment nationwide totalled more than 37 million as of January 1, 1989.

HMOs in general have not been able to do what they originally intended to do — control utilization and health care costs. Mature HMOs, those operating 4 years or more, typically experienced increases of 18% in inpatient costs; 19% in the cost of physician services; 31% in the costs of other professional services; and 92% in the cost of outside referrals. Nevertheless, HMOs and other managed care plans will remain a major force in the health care system for the foreseeable future.

Rationing

Since its inception, this Committee has discussed and reported on medical socioeconomic issues. With each passing year, health costs get more attention from more sources and that scrutiny is expected to continue.

The combination of patient expectations; cost of technology, appropriately trained and compensated health care workers, liability insurance, and health benefits mandated by legislation; and the view of physicians that their moral, ethical, and legal obligation is to do everything possible for the patient, irrespective of cost, add up to a very expensive package. This, combined with the fact that many people have limited or no access to care, has led to a widening discussion on the fundamental issue of how health care dollars, particularly public health care dollars, should be allocated.

Should the return on investment of tax dollars used for health care benefit the individual or society as a whole? Should society prioritize the medical services it will make available to its members? In public programs, should all

services be available to a few or should limited services be available to everyone?

The traditional focus of medicine has been to do everything possible for the individual, regardless of the cost. If individuals are well cared for and healthy, then society as a whole will be better off. That rationale has served the profession and society well for many years.

Recently, technological change has developed faster than our ability to pay for it. Many years ago, leading-edge technology would have been available only to the wealthiest among us. Today, societal attitudes, the courts, plus a greater awareness of the benefits of high-cost, high-tech medicine brought about by the media, have broadened the demand for this type of care at all levels of our society. But the cost of universally providing maximum levels of care has caused some to rethink that position. Our country cannot absorb the costs associated with making all services available to all who want or need them.

In Kentucky, as in other states, coverages in the Medicaid program are established by Congress and state legislatures. The Medicaid budget is fixed by the amount of money a state legislature is willing to commit to the program. Because dollars and covered services are fixed, the only way to balance budgets when revenues fall short or expenses exceed projections is to cut payments to providers and reduce the number of people eligible for the program.

It is this issue that Oregon is attempting to address. Oregon has enacted legislation to prioritize its Medicaid expenditures. Its plan would provide care paid for by Medicaid to all persons whose income is below the federal poverty level. The state would be prohibited from arbitrarily redefining this level for accounting purposes in order to balance the budget. If sufficient dollars are not available to cover the cost of the program, certain services, based on established priorities, not people, would be cut. Whether or not this concept will be successful in the long run remains to be seen. To put its program of prioritized care into effect, Oregon must obtain a federal waiver of Medicaid regulations. That has not been forthcoming as yet.

Because the cost issue is driving these discussions, we felt it might be worthwhile to learn more about costs on a Kentucky-specific basis. We asked representatives of two organizations responsible for the distribution of many of the health care dollars in the state to meet with us. Dwight L. Blackburn, MD, a member of our Committee, and Executive Director for Physician Relations for Kentucky Blue Cross/Blue Shield, and Mark Birdwhistell, Acting Director, Division of Program Development and Budget, Medicaid Services, Cabinet for Human Resources, met with us and shared the following information.

In 1985, Kentucky Blue Cross/Blue Shield added a Human Organ Transplant rider to its coverage. Between 1985 and 1989, Blue Cross subscribers had 24 heart transplants at an average cost of $105,479, not including physician cost or anti-rejection drugs. Two-thirds survived one year or longer. Nationally, heart transplants increased from 719 to 1985, to 1,700 in 1988.

Costs for liver transplants performed on Kentucky patients covered by Blue Cross/Blue Shield averaged $131,538 over the past few years. An estimated 1,500 liver transplants were performed in the US in 1988. The national average cost for liver transplants is $267,000.

The average cost of a kidney transplant in Kentucky is $39,503, and 103 were covered by Kentucky Blue Cross/Blue Shield over the past five years.

Some other examples of low-volume, high-cost services in Kentucky were pancreas transplants, averaging $128,879 per case; bone marrow transplants at $105,000 per case; and a heart/lung transplant at a cost of $157,344. Thus, in this five-year period, $10.5 million in hospital services was provided to 160 people.

It was also noted that in 1989, Blue Cross paid claims of $3.2 million for treating substance abuse and $1.6 million for closed head injuries. This is the experience of only one of the several major carriers in the state.

The Committee would emphasize that in sharing this information, we are in no way criticizing the fact that these procedures were done or the costs associated with them. We use them simply to illustrate the costs inherent in this type of care.

Mr Birdwhistell shared information on Kentucky's Medicaid program which has grown from 316,427 eligible recipients and a $75.8 million budget in 1972 to 344,108 eligible recipients and a budget of $814 million in 1989. While only 27,681 new people became eligible for coverage, program costs increased by $738 million. Estimates are that by 1992, 6,820 people will be eligible for Medicaid at a cost of $1.3 billion. Most of that increase is due to state and federal legislation requiring Medicaid programs to cover more recipients and services. The federal government provides 72% of Medicaid funding and 28% comes from state funds.

It was reported that in 1987, coverage for pregnant women was expanded to those with incomes at or below 100% of the federal poverty level. This increased to 125% of poverty in 1988, and was changed to 133% recently, bringing an additional 15,000 pregnant women and children aged 0-6 years into the program. While this increased coverage has resulted in an improvement for many people, its annual cost will be approximately $70 million in 1992. Beginning in October, Kentucky will be required to cover pregnant women with incomes up to 185% of the federal poverty level and children to age 1. The Medicaid program estimates that the number of people eligible for the program will have increased by 100,000 between 1989 and 1992.

Even with these changes in the program, many other people have no insurance and no other means of paying for care if they need it. If and when they are ever brought into the system, it is doubtful that there will ever be enough money

to provide a maximum level of care to all people. Some compromise will have to be reached.

We believe this issue will be with us for some time to come. The focus of the problem will be on those who cannot pay for care they need. People of means will always have alternatives, even if insurance doesn't cover services they need or want. Someday society will have to come to grips with the economic dilemma of limiting cost while fulfilling its desire to provide access to quality care. When and if it does, where will it draw the line?

Is it appropriate for us as a profession to say we oppose rationing when there are those of us who refuse to see Medicaid or indigent patients? There are more questions than answers to this quandary, but it is clear that physicians, as members of society, will have to take part in these discussions as they develop.

AMA's Health Access America

"Health Access America" is a proposal by the AMA to improve access to affordable, quality health care. It provides 16 comprehensive proposals for providing medical coverage to the uninsured and underinsured while also ensuring high-quality, cost-effective care. AMA's proposal also calls for the development of practice parameters to help ensure high-quality, cost-effective care and professional liability reform to reduce health care costs associated with defensive medicine and high premiums.

KMA's Board of Trustees asked that the Trends Committee review the proposal and comment on it. The 16 points of the proposal are as follows:

1. Effect major Medicaid reform to provide uniform adequate benefits to all persons below the poverty level.
2. Require employer provision of health insurance for all full-time employees and their families, creating tax incentives and state risk pools to enable new and small businesses to afford such coverage.
3. Create risk pools in all states to make coverage available for the medically uninsurable and others for whom individual health insurance policies are too expensive and group coverage is unavailable.
4. Enact Medicare reform to avoid future bankruptcy of the program by creating an actuarially sound, prefunded program to assure the aging population of continued access to quality health care. The program would include catastrophic benefits and be funded through individual and employer tax contributions during working years. There would be no program tax on senior citizens.
5. Expand long-term care financing through expansion of private sector coverage encouraged by tax incentives, with protection for personal assets, and Medicaid coverage for those below the poverty level.
6. Enact professional liability reform essential to reducing inordinate costs attributable to liability insurance and defensive medicine, thus reducing health care costs.
7. Develop professional practice parameters under the direction of physician organizations to help assure only appropriate, high-quality medical services are provided, lowering costs and maintaining quality of care.
8. Alter the tax treatment of employee health care benefits to reward people for making economical health care insurance choices.
9. Develop proposals which encourage cost-conscious decisions by patients.
10. Seek innovation in insurance underwriting, including new approaches to creating larger rather than smaller risk-spreading groups and reinsurance.
11. Urge expanded federal support for medical education, research, and the National Institutes of Health, to continue progress toward medical breakthroughs which historically have resulted in many lifesaving and cost-effective discoveries.
12. Encourage health promotion by both physicians and patients to promote healthier life-styles and disease prevention.
13. Amend ERISA or the federal tax code so that the same standards and requirements apply to self-insured (ERISA) plans as to state-regulated health insurance policies, providing fair competition.
14. Repeal or override state-mandated benefit laws to help reduce the cost of health insurance, while assuring through legislation that adequate benefits are provided in all insurance, including self-insurance programs.
15. Seek reductions in administrative costs of health care delivery and diminish the excessive and complicated paperwork faced by patients and physicians alike.
16. Encourage physicians to practice in accordance with the highest ethical standards and to provide voluntary care for persons who are without insurance and who cannot afford health services.

After reviewing and discussing this proposal, the Committee felt the AMA should be commended on making an attempt to address the issue of health access in America. The Committee felt this effort will focus attention on many areas in need of change. However, many of the concerns commonly voiced by the business community are not addressed and we are hopeful they will be included as the program develops. It was the consensus of the Committee to recommend to the Board that KMA endorse AMA's "Health Access America" proposal.

As Chairman, I appreciate the participation and interest of the members of the Committee.

Robert R. Goodin, MD
Chairman

RECOMMENDATIONS:

1. The Committee to Investigate Changing Trends in Medicine recommends that KMA endorse AMA's "Health Access America" proposal.

Recommendations, Reference Committee 4:

Reference Committee No. 4 would like to commend the Committee to Investigate Changing Trends in Medicine on its excellent and exhaustive efforts related to issues presented in its report. The Reference Committee recommends that Report No. 31 and its recommendation be adopted.

Report of the Ad Hoc Committee on Quality of Care

Addendum to the Report of the Chairman, Board of Trustees

The Ad Hoc Committee on Quality of Care was appointed as a result of Resolution Y, adopted by the 1988 House of Delegates, which dealt with the influence of managed care plans on medical care delivery. The charge originally developed for the Committee was to discuss the issue of quality of care and whether or not quality was threatened in today's competitive environment with its emphasis on cost containment.

Last year the Committee undertook a number of activities to address this question. These included a search for information directly from the membership concerning problems involving access, timely delivery of medical treatment, patient expectations, and physician difficulties with program requirements. A medium-sized employer was interviewed to ascertain the views of management regarding the effect of managed care plans on quality of care delivered, and several discussions were conducted to define managed care, patient involvement in insurance coverage choice, restrictions imposed on patients by care plans, and the limitation of those plans on physician choice of delivery method.

A survey was conducted of 500 physicians randomly sampled on the basis of specialty and rural and urban practice settings. An analysis of that survey is attached. As the Committee learned in the two years of its efforts, quality is definitely affected by the provisions and restrictions of various insurance programs, but that effect cannot be objectively measured.

During the course of its work, the Committee received comments from an individual physician who had been involved in a situation where care was interrupted because of managed care plan revisions. As a result, and at the request of the Judicial Council, an Insurance Bill of Rights for Patients was developed. The intent in developing this document was to furnish it to physicians for discussion with their patients and to provide it to insurance companies in the hope that the proposal would generate some concern for the rights of patients. This Bill of Rights is attached to this report, and it is the feeling of the Committee that this document should be adopted by the House of Delegates and furnished to insurance companies.

In summary, the Committee collectively experienced the same frustrations that many individual physicians encounter daily in dealing with managed care plans on behalf of patients. At the core of this problem is the fact that the physician is a silent third party to insurance contracts and has no voice in the contracting. In earlier days, when simple insurance coverage was at issue, physicians were able to maintain a verbal contract directly with the patient. In this age of managed care plans, however, the physician is relegated to the role of a "provider," and the physician-patient relationship suffers.

The Committee would recommend that all physicians maintain the welfare of the patient uppermost and guard against transmitting to patients their valid feeling of frustration in dealing with managed care plans. The final guarantee of quality is the benevolent concern for healing that is at the base of the profession, regardless of the influence of external forces.

K. Thomas Reichard, MD
Chairman

RECOMMENDATIONS:

1. The Ad Hoc Committee on Quality of Care recommends that the KMA House of Delegates adopt the Insurance Bill of Rights for Patients developed by the Committee and make it available to physicians and insurance companies.

INSURANCE BILL OF RIGHTS FOR PATIENTS

PREAMBLE

WHEREAS, the medical profession has foremost concern for the welfare and care benefits of patients, and

WHEREAS, both physicians and patients are influenced by various factors of insurance coverage and managed care plan provisions in the rendering and receiving of care, and

WHEREAS, quality of care rendered and received should not be abrogated by external, administrative influences, now therefore be it

RESOLVED, that the following guides are adopted by the Kentucky Medical Association and offered to managed care plans for the benefit of the patient.

It shall be the right of the patient to:

- Receive an individual copy of his/her insurance policy in a comprehensible form;
- Have access to an agent of the sponsoring insurance program for purposes of explanation of benefits and other provisons;

- Have the insurance program act as his/her advocate with providers;
- Receive full and timely information on patient responsibilities regarding notification of providers and insurance program representatives prior to nonemergency hospital procedures;
- Be informed of reimbursement limits to providers for given episodes of acute care;
- Be assured of receipt of full benefits commensurate with policy coverage;
- Be advised of the eligibility or participation of facilities and physicians in a given program and the ramifications to the patient if ineligible or nonparticipating providers are involved;
- Be notified in a timely manner of coverage changes prior to episodes of elective care.

ANALYSIS

QUALITY OF CARE SURVEY 1989-90

1. **What approximate percentage of your patients have their bills paid by a managed care plan (health insurance, Medicare, Medicaid, HMO, etc.)?**
   Average — 59% Range — 0-100%
   COMMENTS: It is questionable if the average percentage reported is a true reflection of the average practice setting.
2. **When you treat an individual patient, are you aware of the coverage he/she has?**
   YES — 67%(92) NO — 31%(44)
   COMMENTS: Apparently, most physicians are aware of the patient's coverage before care is rendered.
3. **Do you hesitate to provide services (order lab tests, do in-office procedures, prescribe preferred medications, etc.) for fear that the service is not covered?**
   YES — 44% NO — 52%
   COMMENTS: Owing to the response, this question may not be valid. It asks if a physician hesitates in providing services, rather than if services are provided regardless of insurance coverage. It does indicate, however, that the issue of coverage obviously does have influence on whether or not noncritical services are rendered.
4. **Can you identify any aspects of insurance coverage that have influenced the quality of medical care you provide? Please describe.**
   YES — 62%(89) NO — 29%(42)
   14% Paperwork
   13% Preadmission review
   10% Facilities excluded
   6% Forced early discharge
   5% Drugs excluded
   3% Office lab excluded
   2% Clinical lab excluded
   Other — Inappropriate review, capitation, second opinions, negative impact on decision-making, mammograms, injectables excluded.
   COMMENTS: It is obvious that insurance programs do influence the provision of care, but from the individual responses, no conclusion can be drawn that the quality of care provided by the physician is affected.
5. **Are you aware of any provision of a given insurance plan that has prevented you from rendering a service or providing care in the way you felt was most appropriate? Please describe.**
   YES — 59%(85) NO — 36%(51)
   21% Service not covered
   9% Facility excluded
   8% Preadmission review
   5% Physician excluded
   3% Length of stay
   3% Drugs excluded
   Other — Paperwork, large deductible, inequity in payments to providers, inappropriate review, early discharge.
   COMMENTS: The preponderance of individual responses indicated that the paid insurance provisions that prevented care being rendered in the most appropriate fashion were exclusions or services simply not covered.
6. **Has a hospital bed ever been denied to you for one of your patients because of insurance or plan provisions? Please describe.**
   YES — 25%(35) No — 66%(94)
   7% Facility not eligible
   5% Service not covered
   3% Transfer denied
   3% Retroactive denial
   2% Preauthorization
   2% Elective surgery
   2% Procedure could be outpatient
   2% Patient had no insurance
   COMMENTS: The majority of responses to this question indicate that a hospital bed was not denied if needed, with the obvious exceptions noted.
7. **Have other hospital-based services (e.g., CT scan) ever been denied to one of your patients because of insurance or plan provisions? Please describe.**
   YES — 16%(23) NO —71%(102)
   3% Service not covered
   3% CT
   2% MRI
   1% Retroactive denial
   1% Insurance company requires single source
   COMMENTS: It is felt that question 7 is somewhat ambiguous. The intent was to relate the question to patients already hospitalized, not those being sent to the hospital for testing. The preponderance of responses show that hospital-based services have not been denied if medically necessary.
8. **Are you aware of any difficulties caused by insurance provisions that your patients have encountered directly which have prevented or prohibited access to needed medical services? Please describe.**
   YES — 36%(51) NO — 46%(66)
   8% Service not covered
   5% Cannot see MD of choice
   4% Preauthorization
   2% Hospital not eligible
   2% Deductible too high

COMMENTS: The positive responses were all related to exclusions or issues of noncoverage. Failure to elicit the appropriate response to this question may relate to the lack of awareness on the physician's part of problems that confront patients.

9. **Have any of your patients been prevented from receiving care from you other than for reimbursement issues? Please describe.**
   YES — 20%(28) NO — 67%(98)
   10% Physician not eligible
   3% Service not covered
   1% No insurance
   COMMENTS: The preponderance of responses indicate that patients were not prevented from receiving needed care.
10. **Does the time spent by you meeting administrative requirements affect care you provide other patients? Please describe.**
   YES — 57%(81) NO — 33%(47)
   15% Takes time away from patient care
   12% Too time-consuming
   10% Harrassment factor
   1% Reduces time with family
   1% Should be patient responsibility
   Other — Should not affect patient care, takes time away from CME and research.
   COMMENTS: It is apparent that administrative requirements do affect care provided, primarily because of reduced time available to spend with patients.
11. **Please make any general comments on quality of care you may wish.**
   12% Concern over increased third-party control
   12% Quality of care is affected
   3% Concern for effect on patient

RESPONSE BY GEOGRAPHY:
Rural 24% (34) Urban 73% (104)
RESPONSE BY SPECIALTY:
29% FP
11% IM
10% GS
7% OB
7% PED
5% PSY
3% U
2% OPH
2% ENT
2% RAD

GENERAL COMMENTS:
As determined from earlier analysis, the effect of managed care plans on quality of care delivered cannot be quantified. The survey indicates that quality is affected (subjectively) because of administrative difficulties physicians and patients must face, followed by exclusions from insurance coverage. Primarily, these were reported as ineligible facilities and physician exclusion or nonparticipation.
The preponderance of responders were primary care physicians practicing in an urban setting. The survey process was not valid enough to conclude that this group is most affected, but empirical knowledge would indicate that this is so. Responses to this questionnaire may also reflect the varied experience of physicians in different parts of the state, depending on the competitive nature and diversity of insurance programs operating in a given area. No quantifiable quality issues were divulged by the survey, which makes direct address of quality issues difficult. There is no question that increased administrative burdens that a physician must deal with have a subjective and objective influence on medical practice. Likewise, it is obvious that insurance coverage exclusions and facility and physician eligibility factors affect the delivery of care but, again, no overt influence on quality can be determined.

Recommendations, Reference Committee 4:

Reference Committee. No 4 reviewed the Report of the Chairman, Board of Trustees, Report of the Ad Hoc Committee on Quality of Care, *only*, and its recommendation.

The Reference Committee would like to thank the Ad Hoc Committee on Quality of Care for its attempt to address a difficult subject.

Reference Committee No. 4 recommends that Recommendation No. 1 be amended as follows:

"The Ad Hoc Committee on Quality of Care recommends that the KMA House of Delegates adopt the Insurance Bill of Rights for Patients developed by the Committee and make it available to physicians and ~~insurance companies~~ all third-party payors."

Reference Committee No. 4 recommends that the Report of the Ad Hoc Committee on Quality of Care and its recommendation, as amended, be adopted.

Resolution E

Inequitable Reimbursement
Oris Aaron, MD, Columbia

WHEREAS, there currently is an inequity in reimbursement by third parties to physicians and hospitals in rural areas, as opposed to urban areas in the state, and

WHEREAS, the original architects of the geographical differentials were the Kentucky Medical Association, the Kentucky Hospital Association, and Blue Cross and Blue Shield, and

WHEREAS, Medicare, Medicaid, and commercial insurors were successful in adopting and using these pre-existing payment differentials, and

WHEREAS, rural physicians and hospitals must furnish care while being handicapped by inadequate reimbursement levels, to the detriment of patients and the medical care system, and

WHEREAS, the profession should not be subject to the divisiveness of reimbursement disparities where quality is not an issue, now therefore be it

RESOLVED, that this House of Delegates is opposed to payment differentials to physicians and hospitals based on geographic location, and be it further

RESOLVED, that a copy of this Resolution be sent to

insurors, governmental medical program carriers, the Kentucky Hospital Association, Medicare, and Blue Cross and Blue Shield, and be it further

RESOLVED, that KMA continue a strong leadership role and firmly pursue all channels necessary to remedy this injustice in the interest of fairness and equity to both providers and patients.

Reference Committee No. 4 next reviewed Resolution E, Inequitable Reimbursement, introduced by Oris Aaron, MD, Columbia.

The Reference Committee would like to comment that a representative of Blue Cross and Blue Shield of Kentucky reported that Blue Cross and Blue Shield plans to eliminate geographic areas and have statewide reimbusement effective July 1, 1991.

Reference Committee No. 4 recommends that Resolution E be adopted.

Willim B. Monnig, MD, Chairman of the Board of Trustees, was recognized, who proposed that due to some inaccurate statements in the "Whereas" section of Resolution E, that the Resolution not be adopted. In lieu of Resolution E, Doctor Monnig noted that the Board would offer a substitute Resolution (BB) which would be almost identical to the one submitted by Oris Aaron, MD. Doctor Monnig explained that due to parliamentary procedures, the "Whereas" section in Resolution E could not be amended; therefore the new Resolution was being proposed with most of the same content as Resolution E.

A motion was then made, seconded, and carried not to adopt Resolution E. Doctor Monnig then read Resolution BB, submitted by the Board of Trustees, and moved for its adoption.

Sam Weakley, MD, Delegate from the Jefferson County Medical Society, was recognized, who proposed an amendment by addition of a fourth "Resolved" to Resolution BB. The motion was seconded from the floor, and on a call for the vote, Resolution BB was adopted as amended, as follows:

Resolution BB

Inequitable Reimbursement
Board of Trustees

WHEREAS, there currently is an inequity in reimbursement by third parties to physicians and hospitals in rural areas, as opposed to urban areas in the state, and

WHEREAS, Medicare, Medicaid, and commercial insurors were successful in adopting and using these geographic payment differentials, and

WHEREAS, rural physicians and hospitals must furnish care while being handicapped by inadequate reimbursement levels, to the detriment of patients and the medical care system, and

WHEREAS, the profession should not be subject to the divisiveness of reimbursement disparities where quality is not an issue, now therefore be it

RESOLVED, that this House of Delegates is opposed to payment differentials to physicians and hospitals based on geographic location, and be it further

RESOLVED, that a copy of this Resolution be sent to insurors, governmental medical program carriers, the Kentucky Hospital Association, Medicare, and Blue Cross and Blue Shield, and be it further

RESOLVED, that KMA continue a strong leadership role and firmly pursue all channels necessary to remedy this injustice in the interest of fairness and equity to both providers and patients, and be it further

RESOLVED, that KMA policy should reflect that in the process of instituting single, equitable, statewide reimbursement schedules, insurance companies should not diminish any present reimbursement schedules.

Resolution T

Sentinel Medical Review Organization
Floyd County Medical Society

WHEREAS, the Sentinel Medical Review Organization has recently influenced physicians to perform frequent laboratory tests; i.e., drug levels for all drugs, and unnecessary chest x-rays and sputum cultures, which increase the cost of medical care, and

WHEREAS, this influence, as well as a lack of response to requests to meet with physicians to work toward creating positive relations, has caused a severe negative impact, and

WHEREAS, this negative impact has become so severe that several physicians have expressed the desire not to review records for Sentinel, as well as not accepting new Medicare patients, now therefore be it

RESOLVED, that the Sentinel Medical Review Organization be requested to hold group meetings with local physicians to help resolve these concerns and remedy the negative impact.

Recommendations, Reference Committee 4:

Reference Committee No. 4 next reviewed Resolution T, Sentinel Medical Review Organization, introduced by the Floyd County Medical Society.

The Reference Committee recommends that Resolution T be adopted.

Mr Speaker, Reference Committee No. 4 recommends the adoption of the report of Reference Committee No. 4 as a whole, as amended.

I would sincerely like to thank the other members of the Committee: Laura Spalding Moore, MD, Louisville; Andrew R. Pulito, MD, Lexington; J. Michael Pulliam, MD, Franklin; and K. Thomas Reichard, MD, Louisville. I would also like

to thank Martha Coombs for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 4

David W. Douglas, MD, London, Chairman
Laura Spalding Moore, MD, Louisville
Andrew R. Pulito, MD, Lexington
J. Michael Pulliam, MD, Franklin
K. Thomas Reichard, MD, Louisville

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 5

Thomas K. Slabaugh, MD, Lexington, Chairman

32. Report of the Committee on Maternal and Child Health
33. Report of the Technical Advisory Committee on Physician Services (Title XIX)
34. Report of the Committee on Community and Rural Health
35. Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports

Resolution R — Encouragement of Breastfeeding (KMA Resident Physicians Section)
Resolution S — Use of Steroids and Amino Acids (Floyd County Medical Society)
Resolution V — Equitable Medicaid Payments (Robert N. Alexander, MD, Pineville)
Resolution W — Medicare Supplement Regulations (Jefferson County Medical Society)
Resolution Z — Breastfeeding (Fayette County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 5 reviewed the following items and recommends they be filed by consent of the House without discussion:

32. Report of the Committee on Maternal and Child Health — filed
34. Report of the Committee on Community and Rural Health — filed

Reference Committee No. 5 would like to express its appreciation to the Chairmen and members of these two Committees for their time and effort in dealing with the issues discussed in the reports.

Mr Speaker, Reference Committee No. 5 recommends adoption of the Consent Calendar as a whole.

Report of the Committee on Maternal and Child Health

The Committee on Maternal and Child Health continued its activities during the Associational year. The Committee was very pleased that the Administration and General Assembly responded to the need for additional revenue for maternal and child health.

Patricia K. Nicol, MD, Cabinet for Human Resources, Maternal and Child Health Division, reviewed the Governor's Budget as adopted by the 1990 Kentucky General Assembly and discussed its impact upon indigent mothers and children. Aspects of the budget of interest to the Committee included:

$4.8 million in new funds over the biennium for well-child services, resulting in 2½ times as many children receiving services.

$2.2 million in new funds over the biennium for vaccine.

An $18 million increase for physician reimbursement under Medicaid.

The Committee also discussed SB 239, sponsored by Senator Benny Ray Bailey and adopted by the 1990 Kentucky General Assembly. This bill mandates a 135% differential for physicians in underserved areas of the state which serves to attract physicians to underserved areas. Also, for the first time, state government will be required to increase payment for Medicaid services on a periodic basis.

The Governor's Leadership Conference on Infant Mortality was conducted in 1989 in Frankfort. Participants included health care providers, congressional leaders, and church and lay leaders. The attendees were divided into seven work groups to submit recommendations for reducing infant mortality in Kentucky. The recommendations are currently being reviewed by the Governor's office for fiscal implementation. The Committee continues to be concerned with the delivery of prenatal and infant care in the underserved areas of Kentucky.

The Committee also discussed the role of nurse practitioners in underserved areas but recognized that nonphysician practitioners share the same reluctance to practice in rural areas as do physicians.

The Committee reviewed 1989 House of Delegates referrals to the Committee. Three recommendations were referred to the Committee on Maternal and Child Health by the Board of Trustees:

1. That medical schools study ways to increase exposure of residents to obstetrical practices in rural areas.
2. That a study of the concept of regional prenatal and maternal care centers, including formalized cooperation between obstetricians and family physicians, be conducted.
3. It was recommended that these issues continue to be studied by the Committee on Maternal and Child Health.

The Committee discussed the recommendations, agreeing that cooperation from the state's universities is imperative to implementation of the recommendations. Several alternatives to traditional four-year medical school, internship, and residency were discussed by the Committee.

In the coming year the Committee will continue to discuss these and other issues of relevance to the Committee's charge. On behalf of the Committee, we would like to express our appreciation to the membership and the Board of Trustees for the opportunity to serve.

Danny M. Clark, MD
Chairman

Report of the Committee on Community and Rural Health

The Community and Rural Health Committee considered a variety of issues this year, many of which were a result of legislation passed during the 1990 Kentucky General Assembly. Of significant concern to the Committee was HB 425 dealing with AIDS guidelines. The Bill was complex and addressed many issues, two of which were of particular importance to the Committee and KMA.

The first issue dealt with use of the general consent form. The Bill states:

> A person who has signed a general consent form for the performance of medical procedures and tests is not required to also sign or be presented with a specific consent form to determine human immunodeficiency virus (HIV) infection, antibodies to HIV, or infection with any other causative agent of acquired immunodeficiency syndrome that will be performed on the person during the time in which the general consent form is in effect. However, a general consent form shall instruct the patient that as part of the medical procedures or tests, the patient may be tested for human immunodeficiency virus infection, hepatitis, or any other blood-borne infectious disease if a doctor orders the test for diagnostic purposes.

The second issue concerning HB 425 deals with confidentiality of HIV test results. The Bill establishes that any physician, nurse, or other health care personnel who have a legitimate need can now be permitted to know the test results in order to provide for protection and to provide for the patient's health and welfare. HB 425 became effective in July of this year.

Another piece of legislation of importance to the Committee and KMA was SB 158 regarding all-terrain vehicle (ATV) regulations. In 1988, legislation was introduced regarding ATV safety, but was defeated. The same legislation was introduced in 1990 by the late Senator John E. Trevey, MD, and was the only piece of safety legislation to pass this session. The Bill requires helmets to be worn when riding ATVs and requires the size of the motor to be matched to the size of the individual riding the vehicle.

In addition to legislative issues, other items considered by the Committee included bicycle safety education. Resolution H, adopted by the 1989 KMA House of Delegates, called for KMA to support the education of the public on the efficacy of bicycle safety helmets. This Resolution was referred to the Committee, and it was decided that the local county medical societies would be contacted requesting their support in urging schools in their county to promote bicycle safety education and the use of safety helmets. The American Academy of Pediatrics and Sandoz Pharmaceutical Company have jointly sponsored an educational program to assist in promoting the use of safety helmets. The Committee has contacted their representatives for assistance.

The Committee also discussed Resolution P which was referred by the 1989 KMA House of Delegates. Resolution P called for support of the establishment of the Cabinet for Health and Environment. The KMA House of Delegates took no position, but referred it to the KMA Board of Trustees for study by the Committee. In the meantime, legislation was introduced in 1990 to establish a separate cabinet, but was defeated. The Committee will continue to monitor this issue.

In other issues, Reginald F. Finger, MD, Department for Health Services, reported that as a result of SB 41, a mammography screening program has been developed in the state sponsored by the Department for Health Services which will make breast cancer screening available for asymptomatic women and will provide a referral service for women to whom further examination or treatment is indicated. Approximately 4,500 women will have mammography screenings through local health departments this year with about 11,000 scheduled next year.

Doctor Finger also reported that in 1991 a program will provide HIB vaccine to be administered to children between the ages of six months and two years. In addition, the two-dose measle vaccine is now being administered to students in the sixth grade and higher.

The Committee continues to receive requests for copies of a pamphlet developed in 1985 on child abuse entitled, "Recognizing and Reporting Child Abuse." The pamphlet was initially mailed to all physicians, hospitals, emergency centers, health departments, and public schools in the state to assist in recognizing and reporting child abuse.

On behalf of the Committee, we appreciate the opportunity to participate in the Association and be of service to the members.

Ardis D. Hoven, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Technical Advisory Committee on Physician Services (Title XIX)

The KMA Technical Advisory Committee on Physician Services (Title XIX) dealt with a number of issues this year on behalf of the membership.

The Committee discussed with Roy Butler, Commissioner for Medicaid Services, the proposal of the Kentucky Medical Assistance Program to remove single-source, nonsteroidal, anti-inflammatory drugs (NSAIDS) from the Medicaid drug formulary. The Commissioner indicated this action was necessary in order to control the expense of the program, but at the same time provide for a mechanism to make NSAIDS available to those Medicaid recipients who have a need for them. The Committee was informed that NSAIDS will be covered on a preauthorization basis whereby the physician would complete a form, a copy of which the patient could take to the pharmacy for dispensing of the NSAID prescription. The Physician Technical Advisory Committee endorsed this approach as long as the KMAP would provide for a preauthorization basis in order to enable physicians to provide the drugs for patients as needed.

The Physician TAC also expressed concern that pain medications on the Medicaid formulary are all controlled substances. Because of their habit-forming nature, it was felt advisable to have some noncontrolled pain medications available on the formulary.

The Physician Technical Advisory Committee responded to a concern of the Formulary Subcommittee with the decline in the utilization of Amoxicillin Trihydrate. The Committee informed the Formulary Subcommittee that some illnesses, such as the H-Flu virus and B. Cat are resistant to Amoxicillin and need treatment with Ceclor or Augmentin.

Another matter of importance to the Physician TAC was a decision by KMAP to put H II Blockers for ulcer treatment on a preauthorization basis. The procedure will operate much like the process being used for NSAIDS, and physicians will no longer have to depend upon the call-in system to obtain approval for use of these specific ulcer-treating medications. Another step in streamlining the call-in system problems that have been encountered by physicians is a plan by KMAP to add additional lines and staff to respond to providers.

Commissioner Butler also met with the Committee regarding KMAP's possible expansion of the KenPAC Program to cover all Medicaid recipients. The Committee concurred with this expansion.

In June of this year, Commissioner Butler and Deputy Commissioner Janie Miller met with the Technical Advisory Committee on Physician Services and with KMA's President and Chairman of the Board of Trustees to discuss the KMAP budget for the upcoming biennium. The budget for fiscal year 1990-91 was $937 million; the FY 1991-92 budget is $1.3 billion. Also, the number of eligible participants in the KMAP is projected to increase from 370,000 to 450,000 by the second year of the upcoming biennium. This increase is due to both federal and state updates, including coverage for all pregnant women and children to six years of age residing in families with incomes below 133% of the federal poverty line. Also, the state of Kentucky has increased coverage of children up to age one to 185% of the poverty level.

At the June meeting the Committee discussed the approved increase of $18 million for the physician fee component for the upcoming fiscal year. It was noted that the average physician reimbursement rate was approximately 50% of current charges and that some physicians average as low as 20 to 30% of their UCR. The Physician TAC requested that KMAP explore the possibility of adopting a flat, uniform reimbursement for office visits and other physician fees which might be a more equitable method of reimbursement and that KMAP should be prudent in reimbursing for new "state-of-the-art" types of procedures.

The Commissioner indicated that he and Deputy Commissioner Miller would explore the present methodology of reimbursing physicians, including the possibility of eliminating the four arrays that are currently used in distinguishing between different specialties. The Commissioner indicated he might need additional input from KMA in order to determine reimbursement suggestions for certain codes.

Since that time, we have received information from Commissioner Butler that, effective July 1, 1990, new formulae for reimbursing physicians under the Kentucky Medical Assistance Program will be in effect. The formula for physician reimbursement for each outpatient service will be 65% of the median billed charges over the 12-month period for calendar year 1989. This figure will be reimbursed at 65% under Medicaid. For inpatient services, the same formula is to be used for physician reimbursement except that the inpatient services shall be reimbursed at 50% of the median.

The Physician Technical Advisory Committee regrets that Joan Thomas, MD, resigned from the Committee this year due to the closing of her practice. We are pleased, however, that O'Tayo Lalude, MD, a family physician from Louisville, has been appointed to the Physician TAC.

My appreciation is extended to other members of the Committee and to all physicians who participate in the Kentucky Medical Assistance Program.

Harold L. Bushey, MD
Chairman

Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed the Report of the Technical Advisory Committee on Physician Services (Title XIX) and recommends that the Report be filed.

Reimbursement procedures for physicians under the Kentucky Medical Assistance Program were discussed, and testimony was given that Medicaid reimbursement had, in

fact, been reduced for many procedures, particularly some of those performed by specialists. According to the Report of the Technical Advisory Committee, Commissioner Butler indicated that physician reimbursement for outpatient services will be 65% of the median billed charges over the 12-month period for calendar year 1989 and 50% for inpatient services. The Reference Committee indicated that it would be impossible for actual reimbursement to be reduced if those guidelines were followed. The Reference Committee recommends this matter be investigated by the Technical Advisory Committee on Physician Services (Title XIX) and that information on the Committee's findings be presented to the House of Delegates in 1991.

Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports

The Committee on School Health, Physical Education, and Medical Aspects of Sports conducted two official meetings during the 1989-90 Associational year. A major emphasis of the Committee related to Resolution X which was adopted by the 1989 KMA House of Delegates. Resolution X, as adopted, declared cheerleading a sport and recommended that appropriate supervision be provided during cheerleading practice, games, and competitive events.

The Committee established a subcommittee on cheerleader injuries chaired by Linda H. Gleis, MD, Louisville. Doctor Gleis has corresponded with the President of the Kentucky Association of Pep Organizations (KAPOS) and the two groups are working together to develop an organized program to reduce injuries. The Committee learned that the Kentucky High School Athletic Association (KHSAA) has a catastrophic insurance plan on high school cheerleaders; however, cheerleaders are required to follow rules set forth by KAPOS.

The Committee discussed the fact that cheerleading sponsors are not required to attend a sports medicine symposium, even though the KHSAA has given favorable indication in this area. It was the Committee's understanding that all high school cheerleading sponsors are teachers, are held responsible for injuries, and fall under the jurisdiction of KHSAA. The Committee recommended to the State Board of Education that high school cheerleader sponsors be required to attend a symposium, sanctioned by the Committee, on sports injuries relating to cheerleaders. A representative of the Committee appeared before the State Board of Education at its March 1990 meeting to present the views of the Committee on this issue. Subsequently, the Department of Education amended the present regulation. The regulation, as adopted, requires all athletic team head coaches, including cheerleading squad coaches, to be certified annually for CPR and to attend a sanctioned sports medicine symposium biennially. This requirement is already in force for athletic team coaches; however, cheerleading coaches will have until December 31, 1992, to fulfill this requirement. The subcommittee has already begun work on these symposia which will be offered by the Committee in 1991.

There was an aborted attempt in June 1990 to delete these regulations. However, a letter was mailed to legislators outlining KMA's efforts in the area of health and safety and the need for mandatory attendance by coaches. In addition, in our testimony before the legislative committee, it was pointed out that in the five years of mandated attendance for head coaches, soft tissue injuries in high school athletes had decreased from 73% to 34%. The Administrative Regulation Review Subcommittee responded to KMA's position and readopted the regulation.

In 1989, the Committee conducted 12 symposia in various areas of Kentucky including Lexington, Madisonville, Paris, Owensboro, Ashland, Northern Kentucky (2), Paintsville, Louisville (2), Elizabethtown, and Murray.

In 1990, symposia were conducted in Madisonville, Louisville, Elizabethtown, Richmond, Paintsville, Lexington, Northern Kentucky (2), and Murray.

These medical symposia are designed to teach coaches how to deal with medical emergencies on the sports field. A booklet relating to sports injuries was developed by the Committee and will be given to every coach in 1990. Topics include heat illness and heat stroke, treatment of soft tissue injuries, and identification and proper stabilization of neck injuries until medical care is obtained. Cardiopulmonary resuscitation (CPR) training is also offered. During the past few years, the Committee has also distributed 20,000 pamphlets on the hazards of drug abuse and will continue its efforts against drug abuse in the future.

The Legislature and the Department of Education also strengthened the attendance requirement by mandating that expenses for attending the symposia be the responsibility of the school system. Compliance shall not be excused for any covered athletic team or cheerleading squad head coach except upon application to the State Board for Elementary and Secondary Education and demonstration of compelling and convincing reasons for noncompliance. Penalties for noncompliance include not allowing the coach to perform coaching duties for one season in the sport which was not represented, or not allowing the coach to perform coaching duties in KHSAA-sponsored championship competition for one season in the sport which was not represented. Thereafter, no member school shall employ as a coach any person not currently certified in sports medicine symposium attendance.

In order to make the symposia more accessible to all coaches, the Committee is in the process of developing guidelines whereby local schools and team coaches can organize and conduct local seminars. However, to be officially sanctioned, approval for these programs must be given by the Committee.

The Committee is extremely pleased with the comple-

tion of the booklet "A Syllabus of Sports Injury Care for the Kentucky High School Coach." The 64-page syllabus, a high-quality manual for coaches, includes various topics on athletic injuries and illnesses, conditioning, matching of athletes, use and abuse of drugs, female athlete problems, and legal aspects. The booklet was typeset, printed, and compiled at KMA Headquarters and we received substantial grants from various sources to offset the cost of printing and mailing. Every head coach in the state will receive a copy free of charge.

We have had a very busy year and I want to recognize the members of the Committee for their outstanding contributions to the children in Kentucky and their efforts to make the sports environment healthy and properly supervised. We also appreciate the continuing support of the thousands of physicians in Kentucky who serve as team coaches, participate in annual physical exams for teams, and who generously support sports programs. Finally, credit should be given to the Kentucky High School Athletic Association, the State Board of Education, and the Kentucky General Assembly for supporting the Committee in its efforts in school and sports safety.

R. Quin Bailey, MD
Chairman

Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed the Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports and recommends that the Report be filed.

The Reference Committee commends the Committee for its work, particularly the preparation and distribution of the booklet, "A Syllabus of Sports Injury Care for the Kentucky High School Coach." Because of some of the dietary advice being given to students by coaches and trainers, Reference Committee No. 5 suggests that the Board of Trustees ask the Committee on School Health, Physical Education, and Medical Aspects of Sports to investigate providing information to high school coaches and trainers regarding appropriate nutrition. Existing sources could be utilized for obtaining this information.

Resolution R

Encouragement of Breastfeeding
KMA Resident Physicians Section

WHEREAS, the American Academy of Pediatrics supports breastfeeding as the superior method of infant feeding, and

WHEREAS, the physical, emotional, and economical benefits of breastfeeding are well known to the medical community, and

WHEREAS, patient education of the benefits of breastfeeding is a major factor in the decision to nurse, and

WHEREAS, many patients in prenatal clinics and in obstetric practices may not receive this information prior to delivery, now therefore be it

RESOLVED, that the appropriate KMA committee study and recommend ways to encourage education of prenatal patients in the benefits of breastfeeding.

Resolution Z

Breastfeeding
Fayette County Medical Society

WHEREAS, all available knowledge indicates that human milk optimally enhances the growth, development, and well-being of the infant by providing the best possible nutrition, protection against specific infections and allergies, and the promotion of maternal and infant bonding, and

WHEREAS, the incidence and duration of breastfeeding among all women in Kentucky is significantly lower than the national average and is especially low among low-income families, and

WHEREAS, breastfeeding has benefits for society through stronger family bonds, women's fulfillment of their aspirations for motherhood and increased self-esteem, and decreased health care costs for infants, and

WHEREAS, the families of Kentucky rely on their health care professionals to provide them with information, counseling, and support to make informed choices about the care and feeding of their infants, now therefore be it

RESOLVED, that the Kentucky Medical Association fully supports breastfeeding and its promotion in the state of Kentucky, and be it further

RESOLVED, that the KMA encourages its members to motivate actively all mothers and their families to initiate and continue breastfeeding, and to review and modify clinical policies and practices which may deter successful breastfeeding.

Recommendations, Reference Committee 5:

Reference Committee No. 5 considered Resolution R, Encouragement of Breastfeeding, introduced by the KMA Resident Physicians Section, and Resolution Z, Breastfeeding, introduced by the Fayette County Medical Society, together because of their subject matter.

Reference Committee No. 5 recommends that since no conflict exists between the two Resolutions, both Resolution R and Resolution Z be adopted.

During the meeting, the Reference Committee was made aware that informational pamphlets on breastfeeding are available to physicians' offices through the WIC Program.

Resolution S

Use of Steroids and Amino Acids
Floyd County Medical Society

WHEREAS, there is great concern among physicians regarding the nonmedical, widespread use of steroids and amino acids among school children, now therefore be it

RESOLVED, that the Kentucky Medical Association urge the introduction and passage of appropriate legislation to require mandatory drug testing for high school students, and be it further

RESOLVED, that such a drug testing program include an appropriate financial allocation.

Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed Resolution S, Use of Steroids and Amino Acids, introduced by the Floyd County Medical Society. Because the Resolution calls for mandatory drug testing for high school students and would require financial allocation for such a program, Reference Committee No. 5 recommends that Resolution S be referred to the Board of Trustees for further study.

Resolution V

Equitable Medicaid Payments
Robert N. Alexander, MD, Pineville

WHEREAS, the Kentucky Medical Assistance Program has traditionally reimbursed physicians at rates far removed from usual and customary charges, and

WHEREAS, the disparity between charges and reimbursement has been greatest in those specialties other than primary care, and

WHEREAS, many physicians have long supported the Medicaid program, despite payment levels, in the interest of patient welfare and benevolent professionalism, and

WHEREAS, recent payment method changes have not acknowledged some of these physician contributions, but have even resulted in reimbursement diminished from previous levels, now therefore be it

RESOLVED, that KMA adopt a policy that reimbursement methods should not discriminate against any class or specialty of physicians, and be it further

RESOLVED, that KMA urge the Department of Medicaid Services and the Cabinet for Human Resources to examine the Medicaid reimbursement policy, and be it further

RESOLVED, that this policy should reflect reimbursement levels proportionate to charges and level of skill and training, regardless of physician location or specialty.

Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed Resolution V, Equitable Medicaid Payments, introduced by Robert N. Alexander, MD, of Pineville, and heard testimony regarding the Resolution.

Reference Committee No. 5 recommends that Resolution V be adopted.

Resolution W

Medicare Supplement Regulations
Jefferson County Medical Society

WHEREAS, Medicare is intended as a federally funded program to assure access to needed medical care to elderly citizens, and

WHEREAS, elderly citizens may be easily confused regarding insurance coverage, and

WHEREAS, managed care insurance supplemental contracts in Kentucky have been allowed to restrict Medicare patients to designated participating hospitals and physicians, and

WHEREAS, misunderstanding of these restrictions by Medicare beneficiaries has led to delays in emergency care, disruption of the physician-patient relationship, and possible adverse financial impact upon persons intended to be protected by Medicare, and

WHEREAS, the Insurance Commissioner of Kentucky has been decidedly unresponsive to concerns expressed by the Kentucky General Assembly, the Kentucky Medical Association, and the Jefferson County Medical Society in this regard, now therefore be it

RESOLVED, that the Kentucky Medical Association draft legislation or regulations to standardize Medicare supplement policies issued in Kentucky, and be it further

RESOLVED, that Medicare supplement policies written by health maintenance organizations not be excluded from these restrictions, and be it further

RESOLVED, that such draft legislation or regulations be consistent with model regulations developed by the National Association of Insurance Commissioners (NAIC), in that

— Medicare supplements pay all or none of the Part A deductible, and
— pay at least 20% of Part B provider copayments, regardless of location of care.

Recommendations, Reference Committee 5:

Reference Committee No. 5 reviewed Resolution W, Medicare Supplement Regulations, introduced by the Jefferson County Medical Society, and heard considerable testimony regarding this Resolution.

Reference Committee No. 5 was enthusiastic about this Resolution due to the problems that exist with Medicare supplement policies, and recommends it be adopted.

Mr Speaker, Reference Committee No. 5 recommends

the adoption of the report of Reference Committee No. 5 as a whole.

Mr Speaker, I want to personally thank the members of the Reference Committee who, by their deliberations, have attempted to assist this House of Delegates. Members of the Committee are Frank H. Catron, MD, Corbin; John R. Potter, MD, Ashland; Kerry L. Short, MD, Louisville; and James O. Willoughby, MD, Bowling Green. I also want to personally thank Doris Crume for her assistance in the preparation of this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 5

Thomas K. Slabaugh, MD, Lexington, Chairman
Frank H. Catron, MD, Corbin
John R. Potter, MD, Ashland
Kerry L. Short, MD, Louisville
James O.Willoughy, MD, Bowling Green

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 6

William P. VonderHaar, MD, Louisville, Chairman

36. Report of the Judicial Council
37. Report of the Rural Kentucky Medical Scholarship Fund
38. Report of the Physician-Attorney Liaison Committee
39. Report of the Membership Committee
40. Report of the Committee on Constitution and Bylaws
41. Report of the Young Physicians Steering Committee
42. Report of the Medical Student Section
43. Report of the Resident Physicians Section
44. Report of the Ephraim McDowell Cambus-Kenneth Foundation

Resolution G — Use of Seat Belts (Fayette County Medical Society)
Resolution J — AMPAC/KEMPAC Membership Drive (Jefferson County Medical Society)
Resolution K — KEMPAC Endorsements (Jefferson County Medical Society)
Resolution P — Local Seat Belt Laws (KMA Resident Physicians Section)
Resolution Q — Regulation of Water Jet Skis (KMA Resident Physicians Section)
Resolution U — Membership Dues (Floyd County Medical Society)
Resolution X — Gun Control (Jefferson County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 6 reviewed the following items and recommends they be filed by consent of the House without discussion:

36. Report of the Judicial Council — filed
38. Report of the Physician-Attorney Liaison Committee — filed
39. Report of the Membership Committee — filed
41. Report of the Young Physicians Steering Committee — filed
42. Report of the Medical Student Section — filed
43. Report of the Resident Physicians Section — filed
44. Report of the Ephraim McDowell Cambus-Kenneth Foundation — filed

Mr Speaker, Reference Committee No. 6 recommends adoption of the Consent Calendar as a whole.

Report of the Judicial Council

The Judicial Council met several times this year. The majority of issues considered involved patient complaints. Additionally, some major policy matters were considered. Some notable changes took place, too, on the Council membership.

More inquiries were received from physician members this year than previously. In one physician-initiated action, a surgeon who was scheduled to perform a procedure on a patient the following day had been notified by the insurance company that he was not eligible to participate in the patient's managed care plan, and the surgery was cancelled. Not only was this unprofessional conduct by the insurance company, but it was insensitive to the needs and concerns of the patient. The physician suggested that a patient's Bill of Rights would be appropriate for such circumstances. The Council agreed and requested that the Board of Trustees seek the development of such a document. This was referred to the Ad Hoc Committee on Quality of Care, which did produce a Bill of Rights.

The Council made several referrals to the Board of Medical Licensure this year when the individual matter in question warranted. While the Council feels it should remain the final arbiter on questions of ethics and propriety, some situations do indicate Licensure referral because corrective action is more appropriate to the Board of Licensure's jurisdiction.

In two cases the Council became aware of patterns of overutilization of services and questions of medical necessity by physicians. Because it was the Council's view that these practices did constitute patterns, they were referred to the Licensure Board for investigation.

In regard to Judicial Council action following disciplinary actions taken by the Board of Medical Licensure, guidelines were developed and adopted. The guidelines make

reference to disciplinary actions against members for various specific reasons related to licensure. Essentially, the guidelines call for no action if medical licenses are on probation. If a license is suspended, the individual no longer qualifies for any of the definitions of members, and membership is denied for the term of the suspension. If a license is revoked, membership is pro forma denied.

The Council became involved this year in some policy issues, aside from medical practice questions. In one situation, the Council determined a serious question of confidentiality of medical records. After a homicide involving a physician occurred, the patient's records were released to the media by the coroner's office. It was learned that the coroner does have subpoena power in such a circumstance, but public release would still seem to belie confidentiality tenets. Further efforts are being directed toward this matter.

Numerous complaints from patients were heard this year. The majority could have been resolved through better physician-patient communications. Some had validity from a medical practice standpoint, as far as the patient was concerned. Some of these matters showed errors in medical judgment; some were the result of simple mistakes; and some were, essentially, the result of a lack of rapport. Most, however, could have been avoided or resolved if physicians and patients had spoken more candidly with one another.

These matters included a question of whether or not a physician had withheld care because of an outstanding bill, questions by patients about the possibility of unnecessary services and excessive charges, complaints about the transfer of records between physicians, and complaints that involved poor "bedside manner." The Council would urge that all physicians be more attentive to patient needs, both spoken and unspoken. Better relations can certainly improve the delivery of medical care, and results due to poor communication ranging from unpleasantness to liability suits can be avoided.

The Council was pleased this year to be joined by Paul J. Parks, MD, Bowling Green. Doctor Parks has brought to the Council wisdom and stature and has certainly aided the Council's efforts and the profession. The Council notes with regret the end of service of two long-time members. Harold L. Bushey, MD, Barbourville, is retiring from the Council because of the end of his constitutional tenure. Doctor Bushey has been a faithful servant of the Council and the membership. His dedication and devotion will be missed.

The Council also notes the retirement of S. Randolph Scheen, MD, Louisville. Doctor Scheen has sat on the Council by virtue of his position as Secretary-Treasurer, and he is resigning that post, likewise. Obviously, he has served the Council longer than any sitting member, and his departure is truly the passing of an era. His soundness of thought, dignity, and quiet humor will be sorely missed, and his untiring effort cannot adequately be quantified.

As Chairman, I would like to thank all members of the Council, and I would like to thank the membership for the trust you have placed in the Council members by electing us to serve you.

Will W. Ward, Jr, MD
Chairman

Report of the Physician-Attorney Liaison Committee

The Physician-Attorney Liaison Committee serves as a liaison between the medical and legal professions. The primary purpose is to resolve disputes before they reach the legal state. Duties of the Committee include reviewing complaints, airing grievances, and settling interprofessional problems. The Kentucky Medical Association and the Kentucky Bar Association formed this Committee in 1972-73 to foster improved relations between the two professions. An Interprofessional Code was developed as a result of the formation of this Committee. The purpose of the Code is noted in the implementation section as follows:

> The purpose of this Code is to establish, maintain, and perpetuate a greater degree of understanding and ethics between the respective medical and legal professions. Any abuse of this Code or violations thereof by a member of either profession should be brought to the attention ot the Physician-Attorney Liaison Committee for a determination to be made as expeditiously as possible.

The code is published biennially in the January issue of the *Journal* and will appear in the January 1991 edition. Additional copies of the Code are available upon request.

While the Committee did not receive any official complaints this year, there were numerous phone calls relating to the Code and the Committee's charge. We do, however, note that several local "joint" societies are now operating a physician-attorney committee on local levels. We believe this will better serve the membership and foster a more comprehensive understanding between the physician and attorney.

Once again, we urge members to contact us whenever they have questions or would like to file an official complaint. The Committee is composed of eight physicians and eight attorneys. We look forward to serving during the coming year and will continue to work with the membership and the legal profession to resolve various disputes and disagreements as appropriate.

Lynn L. Ogden, MD
Co-Chairman

Report of the Membership Committee

The Membership Committee is pleased to report that membership in the Association continues to grow and at the

end of 1989 had reached an all-time high of 5,460 physician, resident, and medical student members. At its meeting on March 21, 1990, the Committee reviewed the membership patterns for the past decade noting that Active membership increased 18% and total KMA membership grew 36% during this period. Student and resident membership flourished during the '80s with a 74% increase in student members and a 230% increase in the In-Training category. Also significant was the dramatic rise in Life members which has grown 105% since 1980.

In reviewing the composition of KMA membership, it was pointed out that in 1980 Active members made up 85% of total membership, compared to 78% in 1989. The growth in the number of Life members, from 255 in 1980, which was 7% of total members, to 524 or 11% of all members in 1989, accounts for much of this change in composition.

The statistics on the growth and projected growth of Life members in the next five years indicates that to be fiscally responsible to the Association something needs to be done to stem the increase in this dues-exempt category, yet provide a plan for those members who have contributed to this Association for so many years. Recommendations concerning Life membership were referred to the Board which asked the Constitution and Bylaws Committee to frame an amendment for consideration by the House.

Recruitment efforts to increase the number of dues-paying members last year resulted in the addition of 434 total new members (246 Active, 177 In-training, 11 Associate). Although our retention rate was 97% in 1989, we still experienced a loss of 249 Active members due to the following reasons:

55 — Changed from Active to Life
87 — Moved out of State
11 — Died
1 — Ineligible due to Licensure Board action
95 — Did not renew

Even with the addition of 246 new Active members, plus 40 physicians who changed status to Active from other categories, we experienced a net gain of only 37 additional members over 1988. This reconfirms our position that membership development must be ongoing and that we must strive through every means possible to retain current members and convince nonmembers to join.

Recruitment for 1990 members began just prior to last year's Annual Meeting and included two peer-to-peer campaigns and 16 separate statewide and targeted mailings, totaling over 8,200 individual contacts. Routine contact of physicians new to the state or just starting practice has resulted in 68 new members so far this year and continues to have the highest response of direct mail efforts.

As in 1989, the KMA videotape continues to be a successful tool for recruitment as almost 10% of those receiving the video have joined. Because of this positive response, efforts are underway to update the videotape which will be sent primarily to new physicians who have not responded to other mailings.

Developed in 1988 as a pilot project, the success of the KMA video has received national attention and KMA staff participated in two national meetings of the AMA last year to speak about the development and results from the video. Requests for copies of the tape have come from more than 20 other state associations.

The peer-to-peer campaigns conducted this year were by KMA's Alternate Trustees and the Young Physicians Steering Committee. The Committee would like to thank Alternate Trustees James Gwinn, MD, Paducah; Christopher McCoy, MD, Owensboro; Thomas Slabaugh, MD, Lexington; Scott Scutchfield, MD, Danville; and Paul Smith, MD, London, for contacting nonmembers in their Districts. Steering Committee members Annette Toler, MD, Louisville, and H. Michael Oghia, MD, Russell Springs, were honored at the AMA Annual Meeting for their participation in a young physicians outreach program.

The Committee also recognizes the officers and staff of the Fayette and Jefferson County medical societies who have been actively involved in recruitment this year. Several mailings and invitations to nonmembers to participate in society programs have contributed to the addition of 147 new members for these two counties. An updated federation brochure was developed this year and, for the first time, includes a personalized version for the Northern Kentucky Medical Society, which boasts 22 new members this year. Other counties to be commended for their membership increases include Hopkins and Hardin each with eight new members; Franklin with six; and Christian, Harlan, Madison, McCracken, and Warren, each with five new members.

Retention of current members is a growing concern as noted previously with the loss last year of 95 Active members who did not renew. Following the initial billing in November, five separate mailings were sent to encourage continued membership. Additionally, for the sixth year, KMA's Executive Committee conducted a nonrenewal phonathon on April 11. Of those contacted, 80% indicated they would renew. To date, 37, or 61%, have done so. Of those the Committee was unable to reach, only 18, or 39%, have renewed. This reinforces our belief that a personal contact by a colleague has a positive influence on membership decisions. We wish to thank this year's phonathon participants: William Monnig, MD, Edgewood; John Noonan, MD, Paducah; Lucian Moreman, MD, Elizabethtown; and Nelson Rue, MD, Bowling Green, who deserves special recognition for participating in all of the past six phonathons.

Although membership among students and residents seems to have reached a plateau, they now account for 16% of all KMA members. Students at both medical schools were recognized for their recruitment efforts at the AMA Interim Meeting in December, and currently 80% of all students belong to KMA. At year-end 1989, however, the In-Training cat-

egory had actually declined by 24 members. Additional recruitment efforts are being undertaken this year at the housestaff level and we hope to see this trend reversed in the coming year. The Committee is grateful to Russell Travis, MD, Lexington, and Bob DeWeese, MD, Louisville, for their presentations at this year's Housestaff Orientations held June 28 at the University of Kentucky and June 29 at the University of Louisville. Over 100 new residents joined during these programs.

The Membership Committee once again sponsored a number of practice management workshops, some in cooperation with the Jefferson, Fayette, and Northern Kentucky medical societies. Over 450 physicians, spouses, and office personnel attended this year's workshops which dealt with insurance coding, Medicare changes, office management, and starting a practice. The Committee will continue to review potential member services and welcomes input from KMA members on benefits.

As has been our custom in this annual report, the membership status as of June 30, 1990, follows:

Membership Category	# as of 6/30/90	# as of 12/31/90
Active	3,641	3,656
In-Training	240	248
Total Dues-Paying	4,142	4,152
Total KMA All Categories	5,304	5,460

These figures represent three-fourths of our potential membership. It is the desire of this Committee that all Kentucky physicians become members of the Association and we need to reach that 25% that remain outside the mainstream of organized medicine. Apathy on our part will only impair KMA's ability to preserve a healthy environment for the practice of medicine in this state. Recruitment should be a commonplace occurrence as we talk with nonmember colleagues in the hospital, office, or at social or community activities.

On behalf of the Committee, we wish to thank all the physicians who have worked to recruit new members and encourage others to become involved in these efforts.

Harold D. Haller, Sr, MD
Chairman

Report of the Young Physicians Steering Committee

This was the second full year of existence for the Young Physicians Steering Committee which was appointed with the goal of increasing young physicians' involvement in organized medicine.

KMA sent a Delegate to both AMA-YPS meetings this year. These young physicians participated both in the activities of the AMA-YPS and the caucus of the Kentucky AMA Delegation. The Delegates saw firsthand the significant activities and efforts being made by the AMA on behalf of all physicians and the significant amount of input young physicians have into the deliberations of the AMA House of Delegates.

This year the AMA-YPS Membership Outreach program recognized Annette Toler, MD, and H. Michael Oghia, MD, for their efforts in recruiting young physicians into AMA membership, and we appreciate the efforts made by these two young physicians.

The Steering Committee held one meeting this year which was basically to plan what the Committee thought was an excellent educational opportunity for young physicians in the areas of contracts, legislation, and business practices.

While the Committee felt that it had developed a program with broad interests and we had secured excellent knowledgeable speakers, the program had to be cancelled due to low registration. The Committee is grateful to those speakers who had agreed to donate their time and expertise.

Although we were initially frustrated over the lack of response to our offering, we must keep in mind that it is sometimes difficult for young physicians just beginning their careers to get away for a day or two to attend these meetings. Other states report similar frustrations in their efforts to build interest among young physicians and agree that building involvement in medical organizations among this age group takes some time.

We plan to begin focusing more on encouraging young physicians' input into the activities of the KMA House of Delegates. Young physicians are well represented in the House and we hope to enhance their participation.

The Young Physicians Steering Committee is working to bring more physicians into organized medicine, not only in terms of membership, but active involvement as well.

The Committee appreciates the continuing support of the KMA Board of Trustees and officers of the Association.

Donald J. Swikert, MD
Chairman

Report of the Medical Student Section

The KMA Medical Student Section has once again been very active at all levels of organized medicine. Total student membership to the KMA is now at 670 members, representing 80% of Kentucky medical students. Both the University of Louisville and University of Kentucky MSS chapters received Outreach Program Awards at the AMA Interim Meeting for their excellent recruitment of medical students to the AMA for last year.

Twenty students represented Kentucky at the Interim and Annual Meetings of the AMA-MSS. Kentucky students appointed to national committees included: Baretta Casey, Rules; Joel Shanklin, Credentials; and Christa Singleton, Long Range

Planning and Development as well as Chairperson of a Reference Committee.

Judy Linger, senior medical student at the University of Kentucky, was elected to the AMA-MSS Governing Council in June for the second year and will serve this year as the Council's Chairperson. The KMA-MSS is very proud of her accomplishments and appreciates the members of the MSS delegation who have been active in shaping medicine for the future.

The Section was also represented at two regional meetings at Indiana University and Wright State University for the purpose of sharing ideas for new programs and enhancement of existing programs.

Resolutions introduced by the KMA-MSS at the national and state levels this year included:

1. Animal Research Facility Protection Act called for criminal penalties and financial responsibility to those who trespass upon or damage animal research facilities. This Resolution, adopted by the 1989 KMA House of Delegates, was introduced to the 1990 Kentucky General Assembly and signed into law by Governor Wilkinson on March 14, 1990.
2. Prevention and Education of Unintentional Firearm Accidents in Children was adopted by the AMA-MSS Assembly and the AMA House of Delegates.
3. Organ Donation Education in Medical School Curriculum was adopted by the AMA-MSS Assembly.

Chapter Activities

The University of Kentucky Chapter of the KMA-MSS has been active in a number of programs this year, including an Organ Donor Awareness Week and an organ donation education program which was sponsored by the Kentucky Organ Donor Affiliates (KODA). Cathy Soldo, a 1990 graduate, was the moving force behind this program in which more than 160 medical students have participated, and efforts are underway to incorporate organ donation education into the medical school curriculum. The UK Chapter also held a successful panel discussion on the future of "practicing medicine." The panel was made up of experts in family practice, internal medicine, and surgery.

The University of Louisville KMA-MSS Chapter also had a very successful year. Programs included the establishment of the STATS (Students Teaching AIDS to Students) program and presentation of an AMA program module on animals in research. The UL Chapter is also organizing a "Back to School" program in conjunction with the KMA Physician Manpower Committee and the UL Admissions Office. This program will involve medical students talking to students at their alma mater high schools about a career in medicine and the process of getting into medical school.

The KMA-MSS Governing Council meets quarterly to continue to address issues facing medicine and the future activities of the MSS Section. Approximately 30 students currently serve on KMA committees. We would like to thank KMA for its continued support of the Medical Student Section and for its willingness to accept medical students as colleagues in a common goal. It is the desire of the Section to continue to be an active, contributing force in organized medicine.

Baretta R. Casey
President

Report of the Resident Physicians Section

The mission of the KMA Resident Physicians Section, now in its sixth year, is to encourage physicians who are in postgraduate training in Kentucky to become involved in organized medicine. Representatives from each of the four training programs in Kentucky make up the Section's Governing Council, which met three times last year to discuss and take action on issues of concern.

Since 1984, policy proposed by the KMA-RPS has been adopted at every session of the KMA House of Delegates. The 1989 House adopted three KMA-RPS Resolutions calling for KMA to support public education on bicycle safety helmets, the concept of smoke-free hospitals, and legislation to extend student loan deferment during residency. Several KMA committees have addressed the first two issues during the past year and Kentucky's Congressional Delegation was contacted to support federal legislation for loan deferments.

The Council has monitored this matter throughout the year since Congress passed legislation eliminating "student status" deferments for medical residents. Council members have shared information obtained from their program directors and legislative alerts have been distributed from the AMA. As of the writing of this report, federal legislation is pending to amend the Higher Education Act to permit deferral of payments on student loans during residency training, regardless of duration.

At its meeting on November 20, the Council proposed to hold, for the first time, a statewide meeting of residents during KMA's Annual Meeting. Speakers for the meeting include Belle Kulick, Policy Analyst for the AMA Resident Physicians Section, who will report on current developments concerning student loan issues, and KMA's Delegate to the AMA-RPS, Vaughn Payne, MD, Louisville, who will discuss recent activity at the national level.

New officers were elected at the January 30 meeting and Council members were given an extensive report on legislative activities of the 1990 Kentucky General Assembly. The Council also heard a report on resident membership in KMA. Overall, 33% of all residents are current In-Training members. Although all the residents at Trover Clinic in Madisonville and a majority of those at St. Elizabeth's in Edgewood are members, concern was expressed about involvement at the University of Louisville and University of Kentucky, which

have 46% and 11% membership, respectively. In response to a request by the Council, KMA President-Elect Preston P. Nunnelley, MD, and KMA staff met with several officers from the UK Housestaff to generate interest in the KMA-RPS and a number of new recruitment efforts are being implemented to increase awareness about resident activities.

A newsletter for residents was initiated and the first issue was distributed in March featuring information on activities of the state and national sections, resident workshops, and KMA's Physician Placement and Establish Practice Grant programs. It is hoped that the newsletter will encourage more participation by residents throughout the state.

On June 19, the Council reviewed matters to be brought before the AMA-RPS at its Annual Meeting. Major issues discussed nationally included alcohol and tobacco warnings, environmental issues, contraceptive research, clinical lab regulations, HIV exposure, and violence against residents.

In addition to having representation at the AMA and KMA meetings, a number of residents serve on KMA committees and the Section is represented at meetings of the KMA Board of Trustees.

On behalf of the KMA-RPS Governing Council, I would like to express my gratitude to the House of Delegates and to individual members of KMA for their support and encouragement. As we continue our training in Kentucky, we appreciate the opportunity to have a voice in issues affecting our future practice of medicine.

W. Ford Threlkeld, MD
President

Report of the Ephraim McDowell Cambus-Kenneth Foundation, Inc

On November 2, 1989, several years of dedicated and endless efforts in creating the Ephraim McDowell Cambus-Kenneth Foundation, Inc, culminated in the signing of an Agreement between Mr Joe A. Wallace and Mrs Cecil Dulin Wallace and the Ephraim McDowell Cambus-Kenneth Foundation, Inc. The Foundation was formed by the Kentucky Medical Association for the purpose of accepting from the Wallaces upon their death a 550-acre farm, named the Cambus-Kenneth Farm, located on Highway 127 in Boyle County at the outskirts of Danville. Mr and Mrs Wallace have agreed to devise the Farm to the Foundation in order to pursue future charitable and educational purposes. Also, the Foundation shall preserve the historic buildings located on the Farm.

The Cambus-Kenneth Farm was at one time owned by the pioneer physician, Ephraim McDowell, MD. The Farm served as his summer home and was the site of his death. Also, the office building used by Doctor McDowell still exists on the Farm and shall be preserved along with the other historic structures on the property. The Farm has belonged to Mrs Wallace's family for many years, most of the time, in fact, since Doctor McDowell's death.

The Ephraim McDowell Cambus-Kenneth Foundation was incorporated on May 26, 1988, as a not-for-profit Kentucky corporation. The purposes of the corporation "are exclusively for charitable and educational purposes in promoting an appreciation of history through the acquisition, restoration, and preservation of buildings and properties having special historic significance, including but not limited to the McDowell House and Apothecary Shop in Danville, Kentucky, and medically related charitable and educational purposes and such further charitable and educational purposes as are permitted to corporations" pursuant to federal and state laws. The Farm contains a house which is a fine example of 19th century architecture and is surrounded by buildings which date back to the 18th century, one of which is the earlier-mentioned office of Doctor McDowell. It is the intention of the Foundation to preserve these buildings for historic and educational purposes and that the Farm be used for medical research, humanitarian medical activities, and medical educational activities. Any revenues generated by the Farm shall be utilized to support the efforts of the Foundation.

The assets of the former McDowell Memorial Fund were conveyed by the Kentucky Medical Association to the new Ephraim McDowell Cambus-Kenneth Foundation, Inc. This included the three tracts of property containing the McDowell House at 125 South Second Street in Danville, Kentucky, its furnishings, and the Fund's operating accounts. The Internal Revenue Service has recognized the transfer of the assets and has provided a 501(c)(3) tax-exempt status to the Ephraim McDowell Cambus-Kenneth Foundation, Inc.

Mr and Mrs Wallace have indicated an interest in developing the Farm during their lifetimes, as enounced in the Agreement, and would be most receptive to assisting in these efforts.

The official family of KMA has expressed the gratitude and appreciation of the Association for this valuable gift and for the opportunity to preserve this segment of history involving Doctor Ephraim McDowell. As the future unfolds, the Foundation will oversee the operation of both of these historic homes of Doctor McDowell.

Nelson B. Rue, Jr, MD
President

END OF CONSENT CALENDAR ITEMS

Report of the Rural Kentucky Medical Scholarship Fund, Inc

The Rural Kentucky Medical Scholarship Fund, Inc, (RKMSF) continues to administer its worthwhile programs in an attempt to meet the medical needs of the rural population

by alleviating the maldistribution of physicians.

For the school term 1990-91, the RKMSF made loans of $10,000 each at 5% interest to 11 new applicants, and 11 subsequent loans were granted.

Five recipients are entering residency programs — three in Family Practice, one in Internal Medicine, and one in Internal Medicine/Pediatrics. Eight recipients are currently enrolled in primary care programs. Eight recipients are entering practice in 1990. Eight recipients received forgiveness for loans in 1989-90. Twelve recipients completed their financial and/or practice obligation in 1989-90.

The Establish Practice Grant Program has been expanded and four physicians are practicing in critical counties in the state. Upon completion of a year of practice, each physician will receive a grant of $10,000 per year, for a maximum of four years, to defray his educational debt. The physicians are practicing in the counties of Adair, Knott, Menifee, and Russell.

It has been a pleasure to have served the Fund as President these past four years, a post my father, C.C. Howard, MD, held from 1946 until his death in 1971. While I will continue to serve the Fund, I am pleased to report that Donald R. Stephens, MD, a former scholarship recipient, was elected as the new President of the RKMSF this year. I know he will do an excellent job and I look forward to working with him.

The continued assistance of the Kentucky Medical Association and the dedication, support, and perseverance of the members of the Board of Directors have contributed to the success of the Fund.

Carolyn H. McKinley, MD
President

Recommendations, Reference Committee 6:

Reference Committee No. 6 reviewed the Report of the Rural Kentucky Medical Scholarship Fund and feels that the information provided in the report is incomplete. Reference Committee No. 6 recommends that future reports of the Rural Kentucky Medical Scholarship Fund contain data on numbers of students involved, amounts expended for scholarships, sources and amounts of income, and retention rates, as well as other pertinent information.

Reference Committee No. 6 recommends that the Report of the Rural Kentucky Medical Scholarship Fund be filed.

Report of the Committee on Constitution and Bylaws

The Committee on Constitution and Bylaws met in June of this year to once again consider changes in the Bylaws relating to life membership. As background, we offer the following information.

In 1989 the Membership Committee recommended to the Board of Trustees that the Bylaws be changed to restrict requirements for life membership in the Association because of the increasing number of life members, some of whom have been KMA members for a relatively short time, retire at an early age, and are granted life membership due to retirement. At the direction of the Board of Trustees, the Committee on Constitution and Bylaws proposed wording to restrict life membership to "a doctor of medicine or osteopathy who has reached the age of 70 *and* has retired from active practice." Physicians who were fully retired, but had *not* reached the age of 70 were to become inactive members by a proposed change in the Bylaws presented to the 1989 House of Delegates.

The 1989 Reference Committee reviewing the recommended wording presented by the Constitution and Bylaws Committee heard discussion on this matter and felt that the proposed criteria did not serve the interests of the membership, feeling life membership should be related both to age of retirement and years of service to the Association. The House of Delegates approved the recommendation of the Reference Committee to refer the matter to the Board of Trustees. The Board subsequently referred the matter back to the Membership Committee for further study and recommendation.

In March 1990 the Membership Committee reviewed the increase in the number of life members from 255 in 1980 (7% of the total membership) to 524 or 11% of all members in 1989. Discussion again centered on tying life membership to years of service, recognizing the Association's obligation to those members who have contributed to the Association for so many years. The Membership Committee recommended to the Board that the Bylaws be changed to be consistent with those of the American Medical Association and the Jefferson County Medical Society.

In April of this year the Board of Trustees approved the recommendations of the Membership Committee and directed the Constitution and Bylaws Committee to draft changes in the Bylaws, for consideration by the House of Delegates in September of 1990. Under the proposed changes, the following criteria, approved by the Board of Trustees, would be in effect:

A physician who is fully retired but under age 70 would pay 20% of active dues ($80) — inactive category;

A physician over age 70, who is practicing full time (more than 20 hours per week) would pay full active dues — active category;

A physician over age 70, who is working part time (less than 20 hours per week), would pay one-half active dues — active category;

A grandfather clause would be included to allow current life members to retain that life membership status.

The recommendations requested by the Membership Committee and Board of Trustees are under Chapter I, Sec-

tion 2 (b), hereinafter set forth for your consideration as Recommendation 1, and under Chapter IX, Section 1, hereinafter set forth for your consideration as Recommendation 2.

The Constitution and Bylaws Committee discussed at great length the concern of this Committee and the Membership Committee regarding the availability of life membership to those physicians who have reached the age of 65 and fully retired after 25 or more years of continuous service to the Association. Contained in Recommendation 3 is an additional proposal to allow those physicians to be elected to life membership by their component society.

I would like to take this opportunity to express appreciation to the members of the Constitution and Bylaws Committee for their service to the Association.

R. J. Phillips, Jr, MD
Chairman

RECOMMENDATIONS:

(Note: Proposed changes are set forth in legislative format whereby the language proposed for deletion is bracketed with lines through the wording and new language is underscored.)

1. CHAPTER I. MEMBERSHIP

Section 2.

(b) Life Members. Component societies may elect as a life member any doctor of medicine or osteopathy who has served his profession with distinction and who has [~~either~~] reached the age of 70 [~~or~~] and has retired from active practice. However, any member who had qualified as a life member at the time of the adoption of this amendment, September 26, 1990, shall continue to qualify as a life member. Life members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8, of these Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.

2. CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Member, $400, (except (a) those physicians elected to KMA membership within six months of the completion of their residency, fellowship or fulfillment of government-obligated service shall pay only one-half of the full active member rate their first full year of membership [~~and~~]; (b) those physicians in their second year of practice shall pay only three-fourths of the full active member rate for their second full year of membership; and (c) those physicians who have reached the age of 70 and work 20 hours or less per week shall pay only one-half of the full active member rate per year for their KMA membership); (2) Life Members, no dues; (3) Associate Members, $75; (4) In-training Members, $30, except that in-training members shall not be liable for dues during the first six months of their first postgraduate year in an approved residency program in Kentucky; (5) Inactive Members, $80; (6) Student Members, no dues; (7) Service Members, no dues; (8) Special Members, no dues. The dues during the first year for any active member shall be prorated on a quarterly basis as determined by the date of his application. Dues fixed by these Bylaws shall constitute assessments against the component societies. Unless otherwise instructed by the Board of Trustees (which may institute centralized billing) the Secretary of each component society shall forward its assessments, together with its properly classified roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary-Treasurer of this Association as of the first day of January each year.

3. Recommendation 3 is the recommendation made by the Constitution and Bylaws Committee to the Board of Trustees, which provides: "Further, any member who has 25 years of continuous membership in a state medical society affiliated with the American Medical Association, who has reached the age of 65 and is fully retired, also may be elected as a life member." If approved by the Board of Trustees, this language would be inserted in Chapter I, Section 2 (b) Life Members, and that section with its proposed amendments would then read as follows with the proposed language for addition being underscored:

CHAPTER I. MEMBERSHIP

Section 2.

(b) Life Members. Component societies may elect as a life member any doctor of medicine or osteopathy who has served his profession with distinction and who has [~~either~~] reached the age of 70 [~~or~~] and has retired from active practice. Further, any member who has 25 years of continuous membership in a state medical society affiliated with the American Medical Association, who has reached the age of 65 and is fully retired, also may be elected as a life member. However, any member who had qualified as a life member at the time of the adoption of this amendment, September 26, 1990, shall continue to qualify as a life member. Life members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8, of these Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.

Recommendations, Reference Committee 6:

Reference Committee No. 6 considered the Report of the Committee on Constitution and Bylaws and heard discussion about the proposed changes in the Life membership category. The Reference Committee recommends adoption of Recommendations 1, 2, and 3 of the Report of the Constitution and Bylaws Committee.

The Reference Committee further recommends that the Board of Trustees study and report back to the House a way to address the concerns of those retired physicians under the age of 65 with more than 25 years of membership who desire to maintain active membership privileges not currently allowed under the Inactive category.

Reference Committee No. 6 recommends that the Report of the Constitution and Bylaws Committee and its recommendations be adopted.

Resolution G

Use of Seat Belts
Fayette County Medical Society

WHEREAS, the use of seat belts has been proven to reduce the death rate or serious injury of persons involved in vehicular accidents, and

WHEREAS, a reduction in serious injury will result in lowering health care costs, and

WHEREAS, the Kentucky Medical Association has previously supported child restraining seats, and

WHEREAS, Fayette County now requires the use of seat belts for all drivers and passengers, now therefore be it

RESOLVED, that the Kentucky Medical Association seek legislation that would mandate the use of seat belts statewide.

Resolution P

Local Seat Belt Laws
KMA Resident Physicians Section

WHEREAS, statistics show that only 25% of Kentuckians use seat belts as compared to 46% nationally, and

WHEREAS, studies at three Kentucky hospitals show that unbelted motorists were hospitalized from three to ten times more frequently after crashes, and costs of treatment were two to four times higher, and

WHEREAS, 36 states now have mandatory seat belt legislation, and

WHEREAS, the Kentucky General Assembly has failed to pass mandatory seat belt legislation during the last two legislative sessions, and

WHEREAS, Lexington and Fayette County have passed seat belt ordinances, and

WHEREAS, a similar ordinance proposed in Jefferson County has been supported by the Kentucky Medical Association, now therefore be it

RESOLVED, that KMA urge county and city governments throughout the state to develop local seat belt laws.

Recommendations, Reference Committee 6:

Reference Committee No. 6 considered Resolution G, Use of Seat Belts, submitted by the Fayette County Medical Society, and Resolution P, Local Seat Belt Laws, submitted by the KMA Resident Physicians Section.

Since KMA has supported mandatory seat belt legislation during the past three sessions of the Kentucky General Assembly, it was recommended that the "Resolved" portion of Resolution G be amended by adding the words "continue to" between the words, "Association" and "seek." The "Resolved" portion of Resolution G would then read as follows:

"RESOLVED, that the Kentucky Medical Association <u>continue to</u> seek legislation that would mandate the use of seat belts statewide."

Reference Committee No. 6 recommends adoption of Resolution G, as amended, and recommends the adoption of Resolution P.

Resolution J

AMPAC/KEMPAC Membership Drive
Jefferson County Medical Society

WHEREAS, the Kentucky Educational Medical Political Action Committee (KEMPAC) and the American Medical Political Action Committee (AMPAC) provide invaluable service to physicians by identifying and endorsing candidates for public office who have demonstrated their understanding and support for issues of critical importance to the medical profession, and

WHEREAS, KEMPAC and AMPAC provide desperately needed funds and in-kind assistance to the election campaigns of such enlightened candidates, and

WHEREAS, widespread physician participation is essential for the fair and effective operation of KEMPAC and AMPAC, now therefore be it

RESOLVED, that the Kentucky Medical Association support a drive for 100% KEMPAC and AMPAC membership for 1990-91 among its members.

Recommendations, Reference Committee 6:

Reference Committee No. 6 next considered Resolution J, AMPAC/KEMPAC Membership Drive, submitted by the Jefferson County Medical Society, and recommends that KMA support a drive for 100% KEMPAC/AMPAC membership for 1990-91. Reference Committee No. 6 recommends that Resolution J be adopted.

Resolution K

KEMPAC Endorsements
Jefferson County Medical Society

WHEREAS, the recent endorsement by the Kentucky Educational Medical Political Action Committee (KEMPAC) of a challenger for a congressional seat constituted a change of previous KEMPAC position, and

WHEREAS, this change of policy was accomplished by a telephone poll of Board members following a decision to the contrary in a duly constituted Board meeting, and

WHEREAS, the resulting KEMPAC endorsement of a candidate took place over the opposition of the KEMPAC Board representative of the district affected, and

WHEREAS, the candidate in question was unsuccessful in his primary bid, thereby leaving the Kentucky Medical Association in an awkward and embarrassing position with regard to the incumbent elected Representative, now therefore be it

RESOLVED, that the Kentucky Medical Association respectfully request the KEMPAC Board to establish policy and procedures to ensure that candidate endorsement decisions be made during duly constituted meetings of the KEMPAC Board, and not by telephone poll of individual Board members.

Recommendations, Reference Committee 6:

The Committee next reviewed Resolution K, KEMPAC Endorsements, submitted by the Jefferson County Medical Society, and heard testimony from the KEMPAC Chairman that the recent use of a telephone poll was a very unusual occurrence. The Committee was assured that this situation was unlikely to recur. Accordingly, the Reference Committee recommends that Resolution K be rejected.

Resolution Q

Regulation of Water Jet Skis
KMA Resident Physicians Section

WHEREAS, the operation of motor vehicles in the water is and can be as dangerous as operation of motor vehicles on land, and

WHEREAS, the number of water jet skis has increased dramatically in recent years, and

WHEREAS, there are currently no regulations regarding the safe operation of jet skis, and

WHEREAS, KMA is committed to protecting the welfare and health of the citizens of this Commonwealth, now therefore be it

RESOLVED, that KMA call for a state legislative study on the potential risks of unsafe operation of water jet skis and on ways to provide for regulation of adequate education and operation of water jet skis.

Recommendations, Reference Committee 6:

The Reference Committee considered Resolution Q, Regulation of Water Jet Skis, submitted by the KMA Resident Physicians Section, and recommends that boats and alcohol use in water sports be included in the proposed legislative study. The Committee therefore recommends that the "Resolved" be amended by deletion and substitution, so that the "Resolved" now reads as follows:

"RESOLVED, that KMA call for a state legislative study on the potential risks of unsafe operation of water jet skis ~~and on ways~~, boats, and alcohol use in water sports to provide for regulation of adequate education and operation of water jet skis, boats, and alcohol use in water sports."

Reference Committee No. 6 recommends that Resolution Q be adopted, as amended.

Resolution U

Membership Dues
Floyd County Medical Society

WHEREAS, physician membership dues to all medical organizations, including KMA, average approximately $1500 per year, and

WHEREAS, there is at present no involvement of rural physicians in KMA, nor any enthusiasm to become involved because of the cost of dues, now therefore be it

RESOLVED, that membership dues be reduced in order to recruit more members.

Recommendations, Reference Committee 6:

Reference Committee No. 6 next reviewed Resolution U, Membership Dues, submitted by the Floyd County Medical Society, and recommends that Resolution U be rejected.

Resolution X

Gun Control
Jefferson County Medical Society

WHEREAS, according to articles by the *Washington Post* and information provided by Handgun Control, Inc, in 1988, 31,500 Americans lost their lives as a result of firearms, either by accident, suicide, or homicide, with 20,000 slain by handguns alone, and

WHEREAS, 65,000 Americans were hospitalized as a result of gunshot wounds and an additional 171,000 treated and released, at an estimated cost of $14.5 billion for medical care and rehabilitation, according to Handgun Control, Inc, and

WHEREAS, unfettered access to handguns and firearms by the mentally ill led to Kentucky tragedies, including the

Standard Gravure massacre and the senseless slaying of Louisville family physician John Patrick Casey, MD, in his office, and

WHEREAS, HR 467, commonly known as the Brady Bill, has been introduced in the US Congress and proposes a seven-day waiting period to permit law enforcement officials to keep guns out of the hands of convicted felons and those adjudicated mentally ill, minors, illegal aliens, and drug addicts, and

WHEREAS, every major law enforcement agency in the US and major groups, including the American Medical Association, American Bar Association, and AFL-CIO, have endorsed and are actively supporting HR 467, and

WHEREAS, waiting periods have been proven effective in those states and communities which have adopted reasonable waiting periods before handguns can be purchased, therefore be it

RESOLVED, that KMA endorses and encourages Congress to enact HR 467 (Brady Bill) and calls upon Kentucky's Congressional Delegation to support the legislation, and be it further

RESOLVED, that KMA supports the adoption of appropriate legislation that would restrict the sale and private ownership of large clip, high-rate-of-fire automatic and semi-automatic firearms, or any weapon that is modified or redesigned to operate as a large clip, high-rate-of-fire automatic or semi-automatic weapon.

Recommendations, Reference Committee 6:

Resolution X on Gun Control, submitted by the Jefferson County Medical Society, was next considered by the Reference Committee. The Committee recommends the adoption of the first "Resolved" of Resolution X, calling for KMA to endorse and encourage Congress to enact HR 467 (Brady Bill) and calling upon Kentucky's Congressional Delegation to support the legislation.

The Reference Committee heard testimony regarding the facts involved in the second "Resolved" and felt it had inadequate knowledge of the subject to make a valid recommendation at this time. Reference Committee No. 6 therefore recommends that the second "Resolved" be deleted and the issue referred to the Board of Trustees for further study.

Reference Committee No. 6 recommends that Resolution X be adopted, as amended.

Mr Speaker, Reference Committee No. 6 recommends the adoption of the report of Reference Committee No. 6 as a whole.

Mr Speaker, I would like to thank the members of the Reference Committee for their help with the issues discussed and in the formulation of this report. Members of the Committee were: James C. Cantrill, MD, Georgetown; John W. Collins, MD, Lexington; James T. Engle, MD, Elizabethtown; and Ronald M. Johnson, MD, Owensboro. I would also like to thank Diane Maxey for her help in preparing this report.

Respectfully submitted,
REFERENCE COMMITTEE NO. 6

William P. VonderHaar, MD, Louisville, Chairman
James C. Cantrill, MD, Georgetown
John W. Collins, MD, Lexington
James T. Engle, MD, Elizabethtown
Ronald M. Johnson, MD, Owensboro

ELECTION OF OFFICERS

Charles F. Allnutt, MD, Edgewood, Chairman of the Nominating Committee, presented the slate of nominees for the following general Officers, who were elected by acclamation:

President-Elect	S. Randolph Scheen, MD Louisville
Vice President	William B. Monnig, MD Edgewood
Secretary-Treasurer	William P. VonderHaar, MD Louisville

Doctor Allnutt then presented the nominees for the offices of Delegate and Alternate Delegate to the AMA, and each was elected by acclamation:

Delegates to the AMA (January 1, 1991 to December 31, 1992)	Wally O. Montgomery, MD Paducah
	Robert R. Goodin, MD Louisville
Alternate Delegates to the AMA (January 1, 1991 to December 31, 1992)	Ardis D. Hoven, MD Lexington
	Bob M. DeWeese, MD Louisville

Doctor Allnutt then submitted the following nominations for the offices of Trustees and Alternate Trustees on behalf of the Trustee District nominating committees, and each was elected by acclamation:

5th District Trustee	Joseph E. Kutz, MD Louisville
5th District Alternate	Larry J. Wilson, MD Louisville
6th District Trustee	Jerry W. Martin, MD Bowling Green
6th District Alternate	John D. Gover, MD Bowling Green
8th District Trustee	Mark F. Pelstring, MD Covington

8th District Alternate	John D. Ammon, MD Florence
11th District Trustee	William H. Mitchell, MD Richmond
11th District Alternate	G. Irene Minor, MD Berea
15th District Trustee	Paul R. Smith, MD London
15th District Alternate	Roger A. Acosta, MD Barbourville

ELECTION OF 1991 NOMINATING COMMITTEE

The following physicians were elected by the House of Delegates to serve as the 1991 KMA Nominating Committee:

Henry R. "Hank" Bell, Jr, MD, Elkton
John D. Ammon, MD, Florence
Ralph D. Caldroney, MD, Lexington
Marion A. Douglass, MD, Magnolia
Audrey Spencer, MD, Maysville

Speaker Clark adjourned the 1990 Session of the KMA House of Delegates at 9:40 PM.

1990 CONSTITUTION AND BYLAWS OF THE KENTUCKY MEDICAL ASSOCIATION

CONSTITUTION

Article I.	Name of the Association
Article II.	Purpose of the Association
Article III.	Component Societies
Article IV.	Composition and Meetings of the Association
Article V.	Officers
Article VI.	House of Delegates
Article VII.	Districts, Sections and District Societies
Article VIII.	Board of Trustees
Article IX.	Funds and Expenses
Article X.	Referendum
Article XI.	The Seal
Article XII.	Amendments
Article XIII.	Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies, but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-Elect, a Vice-President, a Secretary-Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each district that may be established; and such other officers as may be provided for in the Bylaws.

Section 2. The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session, annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. Officers of the Association, Delegates and Alternate Delegates of the American Medical Association and five immediate Past Presidents shall be the ex-officio members of the House of Delegates and entitled to vote. All other Past Presidents and Vice-Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable, provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications, and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary-Treasurer, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary-Treasurer to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided

that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I.	Membership
Chapter II.	Annual and Special Meetings of the Association
Chapter III.	The House of Delegates
Chapter IV.	Election of Officers
Chapter V.	Duties of Officers
Chapter VI.	Board of Trustees
Chapter VII.	Discipline-The Judicial Council
Chapter VIII.	Standing Committees and Councils
Chapter IX.	Assessments and Expenditures
Chapter X.	Rules of Conduct
Chapter XI.	Rules of Order
Chapter XII.	County Societies
Chapter XIII.	Amendments

CHAPTER I. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary-Treasurer as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary-Treasurer of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship. And provided further, that the Judicial Council, after a hearing, shall have power to condition membership in this Association upon the physician's agreement to limit the scope of his practice in any manner reasonably calculated to protect the public from the adverse effects of any demonstrated frailty or disability of said member.

Section 2. Membership in the Association shall be divided into nine classes, to wit: Active, Life, In-Training, Associate, Inactive, Student, Service, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state, and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.

(b) Life Members. Component societies may elect as a life member any doctor of medicine or osteopathy who has served his profession with distinction and who has reached the age of 70 and has retired from active practice. Further, any member who has 25 years of continuous membership in a state medical society affiliated with the American Medical Association, who has reached the age of 65 and is fully retired, also may be elected as a life member. However, any member who had qualified as a life member at the time of the adoption of this amendment, September 26, 1990, shall continue to qualify as a life member. Life members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8, of these Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.

(c) Resident Physicians Section. Doctors of medicine or osteopathy who have complied with all pertinent regulations of the Kentucky Board of Medical Licensure and who are serving in AMA approved training programs in Kentucky shall be eligible for membership in the Resident Physicians Section of the Kentucky Medical Association. The Resident Physicians Section shall be governed by its own Constitution and Bylaws, which shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. In-Training members in good standing shall have the right to vote and receive all publications of the Association. In-Training members shall not be counted in determining the number of delegates to which their county society is entitled in the House of Delegates. The Resident Physicians Section will be represented in the KMA House of Delegates by one voting representative elected by the Governing Council of the Resident Physicians Section.

(d) Associate Members. The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other federal governmental service while on duty in the State, but shall not be deemed to include physicians employed on a full-time basis by the Veterans Administration.

(2) Dentists may be invited to become Associate members.

(3) Physicians residing and/or practicing in communities bordering Kentucky who are active members of their home state and county society and who wish to become members of KMA on an other than active basis may become Associate Members.

Associate members shall not have the right to vote nor to hold office, but shall receive *The Journal* and other publications of the Association.

(e) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive *The Journal* and other publications of the Association.

(f) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for membership in the Medical Student Section of the Kentucky Medical Association. This Medical Student Section shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. Membership shall be coincident with the academic enrollment of the student. Student members may not hold office in the State Association, but may be voting members of any State Association committee to which they are appointed. Student members may, however, hold office within the Student Section in accord with the provisions of that Section's Constitution and Bylaws. The Student Section will be represented in the KMA House of Delegates through one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Kentucky College of Medicine, and one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Louisville School of Medicine.

(g) Service Members. Members of the Association in good standing who enter military service and are ineligible for Association membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to April 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to April 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by April 1 are not in good standing.

(h) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not

a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(i) Special Members. Component societies may invite pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society, provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Hospital Medical Staff Section. There shall be a special section for hospital medical staff physicians who already hold membership in KMA. The Hospital Medical Staff Section (HMSS) shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. The Hospital Medical Staff Section shall elect a Delegate and Alternate Delegate to the KMA House of Delegates. The Delegate to the KMA House of Delegates, or his Alternate as the case may be, shall be a voting member of the House and may present resolutions on behalf of the HMSS.

Section 4. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 5. No person who is finally convicted of a felony subsequent to September 26, 1968, shall be eligible for membership in this Association unless and until, upon proper application to the Judicial Council, it is determined that he is morally and ethically qualified. Except as provided in Chapter VII, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association shall be entitled to any of the rights or benefits of membership of this Association.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or such officers as the Board of Trustees may direct. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall register indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of fifty duly elected delegates of the Association. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary-Treasurer shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. The members of the House of Delegates shall be elected by the various component societies in the manner prescribed in Chapter XII of these Bylaws.

Section 6. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 7. Forty percent of the qualified delegates, as defined by Article VI of the constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 8. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary-Treasurer following its introduction. If the author presenting the resolution presents it as an individual member of the Kentucky Medical Association, the resolution shall be signed by him. If the author be a group of members or component society, the resolution shall be signed by the authorized spokesman for that group. Immediately after the resolution has been introduced, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 9. No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 10. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 11. It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 12. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 13. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 14. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 15. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 16. The state shall be divided into the following districts:

No. 1 — Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2 — Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3 — Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4 — Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5 — Jefferson.

No. 6 — Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7 — Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8 — Boone, Campbell, and Kenton.

No. 9 — Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10 — Fayette, Jessamine, and Woodford.

No. 11 — Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12 — Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13 — Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14 — Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15 — Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 17. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 18. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective, except as provided in Chapter VI, Section 4, and except for the selection of the recipient of the Kentucky Medical Association Award (Outstanding Layman) and Distinguished Service Award (Outstanding Physician), which selections shall be made by the KMA Awards Committee.

Section 19. A digest of proceedings of the House of Delegates shall be published and distributed to the membership annually.

CHAPTER IV. ELECTION OF OFFICERS AND DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Section 1. The President-Elect and the Vice President shall be elected from the state at large for a term of one year, the President-Elect succeeding to the presidency at the expiration of his term as President-Elect. A majority vote of those attending and voting shall be required for the election of the President-Elect and the Vice President and on any ballot where a majority is not obtained, the candidate with the least votes shall be dropped and further balloting held until such time as one candidate receives a majority of the votes cast. Delegates to the AMA and their alternates shall be elected from the state at large for terms of two years with the provision that no more than one delegate and no more than one alternate delegate shall be elected from one component society. The Speaker of the House of Delegates, the Vice-Speaker and the Secretary-Treasurer shall be elected for terms of three years. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice-President, Secretary-Treasurer, Speaker or Vice-Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least three years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the Nominating Committee for the next year. The five names receiving the most votes shall form the Committee, and the person receiving the most votes shall be Chairman. In the event that the Chairman so elected is unable or unwilling to serve, or in the event of a tie, the Committee shall elect one of its members as Chairman. The Commitee shall meet at such time and place as determined by the Committee Chairman or the Board of Trustees, and shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the committee shall have a hearing. The Nominating Committee shall verify the eligiblity and willingness to serve of each candidate nominated. The Committee shall accept and post for information all eligible and willing candidates proposed for offices elected from the state at large. Before noon of the day following the opening meeting, the committee shall post on a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nomination, or nominations, for each office to be filled, and shall formally present said nomination, or nominations, to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment. Vacancies occurring on the Nominating Committee by virtue of death, resignation, or disability, shall be filled by appointment of the Speaker.

Section 3. The election of officers and delegates to the AMA and their alternates shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member may make known his availability for any office within the Association. However, it would be regarded as unseemly for any member to actively campaign for his own election.

Section 6. The Delegates representing the counties in each District form the Nominating Committee for the purpose of nominating a Trustee and an Alternate Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting for the purpose of discussing the nomination of the Trustee and his Alternate to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS OTHER THAN TRUSTEES AND ALTERNATES

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit or cause to be visited on his behalf, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice President shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice-President shall succeed to the office of the President.

Section 4. The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a non-voting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary-Treasurer shall advise the Executive Vice President in all administrative matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and as may be prescribed by the Board of Trustees. The Secretary-Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Executive Vice President or his designee and shall be countersigned by the Secretary-Treasurer of the Association. When one or more of the above-named officials are not readily available, four specifically designated representatives of the Executive Committee are authorized to countersign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. The four members of the Executive Committee authorized to countersign vouchers shall be designated by the Board during their reorganizational meeting in September and, whenever possible should be easily accessible from the KMA Headquarters Office. All those authorized to countersign vouchers shall be required to give bond in an amount to be determined by the Board of Trustees. The Secretary-Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary-Treasurer, and the Delegates and Alternate Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the Vice-President, the President-Elect, the Secretary-Treasurer, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, and a majority of the full Executive Committee, to-wit, 5, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Secretary-Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for postgraduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Secretary-Treasurer upon a proper itemized statement but this shall not be constituted to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the authority to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press.

Section 5. The *Journal of the Kentucky Medical Association* shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the *Journal* shall be elected by the Board. All money received by the *Journal* or by any member of its staff on its behalf, shall be paid to the Secretary-Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In the case of disability, the Alternate shall serve until the disability is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in his place and stead.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary-Treasurer acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Vice President whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Vice President shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Secretary-Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Secretary-Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Secretary-Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Secretary-Treasurer. He shall, within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a record of all physicians in the State by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor, or otherwise supervise the publication of *The Journal of the Kentucky Medical Association* and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary-Treasurer of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or a Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary-Treasurer shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All charges of breach of medical ethics brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine shall be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Medical Licensure for this purpose.

Suspension shall be for a specified period during which the member shall remain liable for the payment of dues but shall not be eligible to hold office, attend business meetings or otherwise participate in Associational activities at the county, district or state levels. Upon the expiration of the period of suspension, every suspended member shall be automatically restored to all of the rights and privileges of his class of membership unless the Judicial Council determines that his conduct during the period of suspension indicates that he is unworthy of such restoration, in which event his suspension may be extended or he may be expelled.

Upon the complaint of any member or aggrieved individual involved, the

Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cause for disciplinary action exists. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent, and a representative of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be obseved. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In this case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final. A party aggrieved by the decision of the Judicial Council may seek an appeal to the Judicial Council of the American Medical Association in accordance with the jurisdiction, rules and regulations of that Association.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recommendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary-Treasurer a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

Section 10. No report or opinion of the Judicial Council shall be considered the policy of the Association until approved by the House of Delegates. Any report or opinion of the Judicial Council submitted to the House of Delegates may be accepted or rejected or referred back to the Judicial Council but not modified by the House of Delegates.

CHAPTER VIII. COMMITTEES AND COMMISSIONS

Section 1. The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

Section 2. The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

Section 3. The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary ad hoc committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

Section 4. No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Member, $400, (except (a) those physicians elected to KMA membership within six months of the completion of their residency, fellowship or fulfillment of government-obligated service shall pay only one-half of the full active member rate their first full year of membership; (b) those physicians in their second year of practice shall pay only three-fourths of the full active member rate for their second full year of membership; and (c) those physicians who have reached the age of 70 and work 20 hours or less per week shall pay only one-half of the full active member rate per year for their KMA membership); (2) Life Members, no dues; (3) Associate Members, $75; (4) In-training Members, $30, except that in-training members shall not be liable for dues during the first six months of their first postgraduate year in an approved residency program in Kentucky; (5) Inactive Members, $80; (6) Students Members, no dues; (7) Service Members, no dues; (8) Special Members, no dues. The dues during the first year for any active member shall be prorated on a quarterly basis as determined by the date of his application. Dues fixed by these Bylaws shall constitute assessments against the component societies. Unless otherwise instructed by the Board of Trustees (which may institute centralized billing) the Secretary of each component society shall forward its assessments, together with its properly classified roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary-Treasurer of this Association as of the first day of January each year.

Section 2. Unless otherwise provided by the Board of Trustees pursuant to Section 1 hereof, any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in the latest edition of Sturgis' Standard Code of Parliamentary Procedure, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 3 of this Chapter, all county medical societies in this State which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

The House of Delegates shall have authority to evoke the charter of any component society whose actions are in conflict with the letter or spirit

of the Constitution and Bylaws.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 4. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting resolutions to that effect at special meetings called for that purpose on at least ten days' notice. Copies of the resolution, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 11 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom he is the designated alternate.

A multi-county component society may be disaggregated so that an individual county society may regain independent status when a majority of the members in that county indicate their desire to reorganize. At that time the members from the withdrawing county shall forward a petition containing the signatures of a majority of the members in that county to be validated by KMA. The withdrawing county shall further forward a resolution to the KMA Headquarters Office to be submitted to the House of Delegates at its next regular meeting, requesting recognition as a county society and issuance of a charter, in accord with Chapter XII, Section 1 of the KMA Bylaws. Once this charter is issued, the new county society shall become a recognized entity at the beginning of the following KMA dues year and those counties remaining with the original multi-county unit may continue to function under their pre-existing charter.

Section 5. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 6 and/or 8 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 6. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 7. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 8. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 9. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days, appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership, provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 10. Frequent meetings shall be encouraged and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 11. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of delegates as its component societies would have had. The secretary of the society shall send a list of such delegates to the Secretary-Treasurer of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 12. The secretary of each component society shall keep a roster of its members and a list of nonaffiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary-Treasurer of the Association, on the first day of January of each year or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

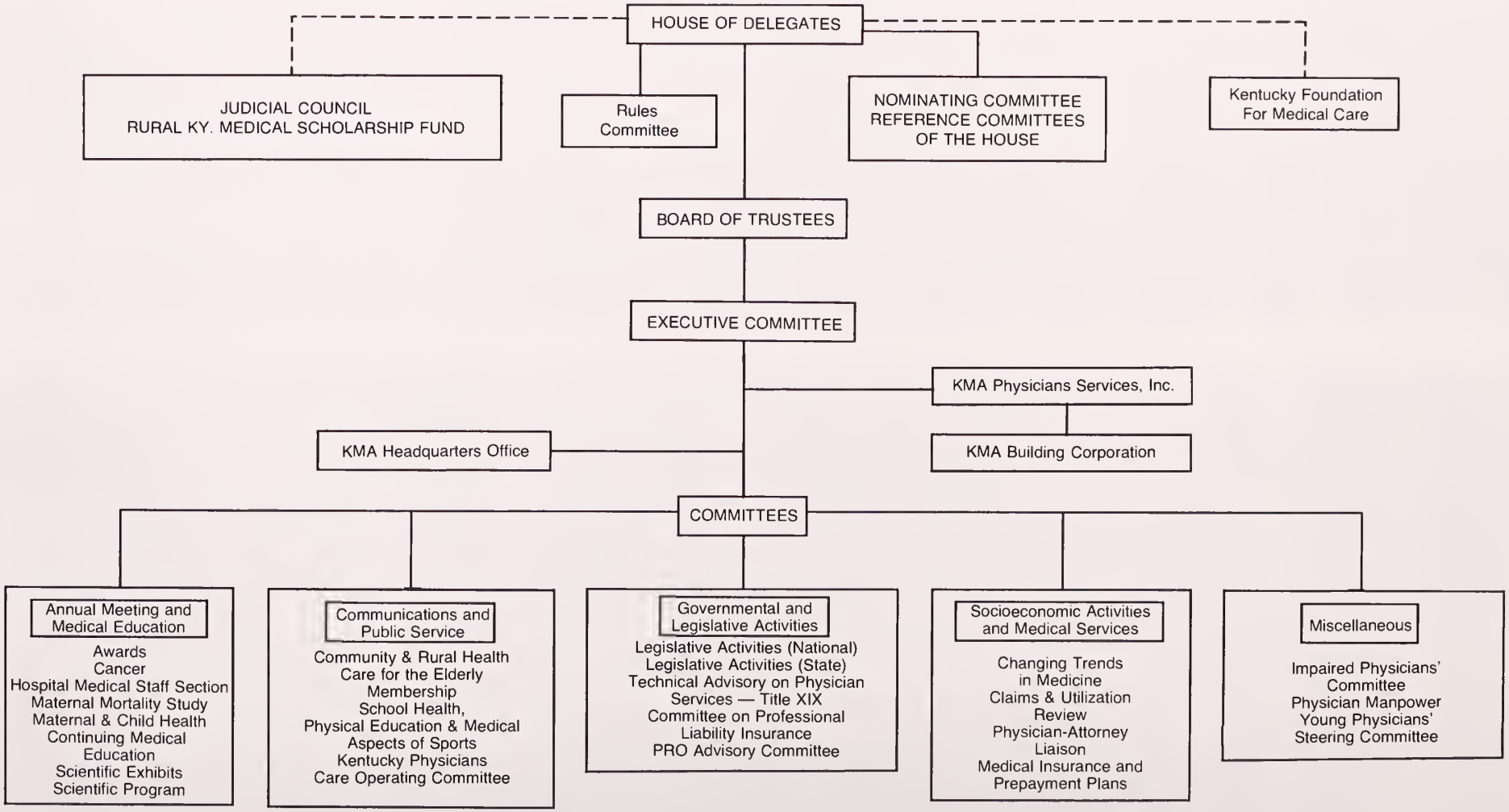
CHAPTER XIII. AMENDMENTS

Section 1. These bylaws may be amended at any session of the House of Delegates by a majority vote of the Delegates present at a meeting of that session, provided: (1) the amendment proposed is presented in writing to the Delegates thirty days prior to the meeting, or (2) the amendment is introduced in writing at a regular meeting of the House of Delegates during the session and considered at the following meeting of the session, the vote on said amendment having been postponed definitely for a period of at least one day.

Section 2. An amendment to or change in the bylaws may be proposed by a reference committee or by the Board of Trustees at the final meeting of a session of the House of Delegates but, not having been postponed definitely for a period of one day, requires a two-thirds vote.

Section 3. An amendment to these bylaws may be proposed in writing by an individual Delegate at the final meeting of a session of the House of Delegates. If such an amendment is proposed, the proposal will be postponed definitely and studied by the appropriate reference committee at that time, reporting their recommendation back to the House of Delegates before the final meeting is adjourned. Such an amendment, having not been postponed definitely for a period of one day, requires a two-thirds vote.

KMA Organization Chart—Revised September 1990



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JANUARY

11-12 — Laparoscopic Cholecystectomy, Washington University Medical Center. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid Ave, Box 8063, St Louis, MO 63110; 800/325-9862, 314/362-6893.

12 — First Annual Pediatric Neuroscience Symposium — "Myelomeningocele: Update on Clinical Management." Sponsored by Kosair Children's Hospital. Contact: Alliant Health System Physician Relations Department, Louisville, KY; 502/562-8659, or 800/292-2759, ext 8659 (in Kentucky); 800/354-6524, ext 8659 (outside Kentucky).

17-19 — Annual Refresher Course and Scientific Meeting presented by The American Academy of Pain Medicine (AAPM) and sponsored by the Mayo Foundation; Omni International Hotel, Miami, FL. Contact: AAPM office, 5700 Old Orchard Rd, First Floor, Skokie, IL 60077-1024; 708/966-9510.

FEBRUARY

24-March 1 — 22nd Family Medicine Review, Session I; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

Feb-April — 32nd Annual Postgraduate Institute for Pathologists in Clinical Cytopathology, Home Study Course A, The Johns Hopkins University School of Medicine, Baltimore, MD. Contact: John K. Frost, MD, or Betty Ann Remley, 111 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, 301/955-8594.

MARCH

13-15 — Seventeenth International Symposium on Psychopharmacology, Holiday Inn-Hurstbourne, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

25 — Dean's Hour — W. O. Johnson lecture, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

APRIL

4-5 — Operative Gynecologic Endoscopy, University of Louisville Health Sciences Center Instructional Bldg, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

12-13 — General Endocrine Review; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

19-21 — Sports Medicine for Physicians; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

25-27 — High Risk Pregnancy Postgraduate Course, Hyatt Regency Hotel, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

26-27 — Contemporary Pediatrics for the Practicing Physician; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

MAY

1-3 — Protection for Research Risk, Hyatt Regency, Union Station, St Louis, MO. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110; 800/325-9862, 314/362-6893.

17-18 — Low Back & Sciatic Pain: Evaluation and Treatment. Presented by Washington University School of Medicine. Contact: Cathy Caruso, Office of CME, Washington University School of Medicine, 660 S Euclid, Box 8063, St Louis, MO 63110, 314/362-6893.

17-18 — Annual Meeting, The Virginia Society of Otolaryngology-HNS, Omni Waterside Hotel, Norfolk, VA. Contact: Donna Scott, 4205 Dover Rd, Richmond, VA 23221, 804/353-2721.

18 — Nephrology Seminar, University of Louisville Health Sciences Center Auditorium, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

19-24 — Twenty-Second Family Medicine Review — Session II; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

JUNE

17-21 — Thirteenth Family Medicine Review, Hyatt Regency Hotal, Louisville, KY. Contact: Laura Tucker, CME, University of Louisville, Louisville, KY 40292; 502/588-5329.

JULY

20-27 — 9th Annual Medical Seminar at Plummer's Great Slave Lake Lodge, Northwest Territories, Canada. Topics in Contemporary Medicine. All specialties. Category 1 — 23 approved CME credits. Sponsored by North Memorial Medical Center and the University of Minnesota Department of Family Practice and St John's Regional Health Center, Springfield, MO. Contact: 612/588-9478.

OCTOBER

27-November 1 — Twenty-Second Family Medicine Review — Session III; Hyatt Regency Hotel, Lexington, KY. Contact: Ms Joy Greene, Director CME, 132 College of Medicine Office Bldg, U of K, Lexington, KY 40503-0086; 606/233-5161.

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Under the Supervision of the Board of Trustees

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VASOTEC®

(ENALAPRIL MALEATE | MSD)

VASOTEC is available in 2.5-mg, 5-mg, 10-mg, and 20-mg tablet strengths.

Contraindications: VASOTEC® (Enalapril Maleate, MSD) is contraindicated in patients who are hypersensitive to this product and in patients with a history of angioedema related to previous treatment with an ACE inhibitor.

Warnings: *Angioedema:* Angioedema of the face, extremities, lips, tongue, glottis, and/or larynx has been reported in patients treated with ACE inhibitors, including VASOTEC. In such cases, VASOTEC should be promptly discontinued and the patient carefully observed until the swelling disappears. In instances where swelling has been confined to the face and lips, the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis, or larynx likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL), should be promptly administered.** (See ADVERSE REACTIONS.)

Hypotension: Excessive hypotension is rare in uncomplicated hypertensive patients treated with VASOTEC alone. Patients with heart failure given VASOTEC commonly have some reduction in blood pressure, especially with the first dose, but discontinuation of therapy for continuing symptomatic hypotension usually is not necessary when dosing instructions are followed; caution should be observed when initiating therapy. (See DOSAGE AND ADMINISTRATION.) Patients at risk for excessive hypotension, sometimes associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death, include those with the following conditions or characteristics: heart failure, hyponatremia, high-dose diuretic therapy, recent intensive diuresis or increase in diuretic dose, renal dialysis, or severe volume and/or salt depletion of any etiology. It may be advisable to eliminate the diuretic (except in patients with heart failure), reduce the diuretic dose, or increase salt intake cautiously before initiating therapy with VASOTEC in patients at risk for excessive hypotension who are able to tolerate such adjustments. (See PRECAUTIONS, *Drug Interactions* and ADVERSE REACTIONS.) In patients at risk for excessive hypotension, therapy should be started under very close medical supervision and such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart disease or cardiovascular disease in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident. If excessive hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses of VASOTEC, which usually can be given without difficulty once the blood pressure has stabilized. If symptomatic hypotension develops, a dose reduction or discontinuation of VASOTEC or concomitant diuretic may be necessary.

Neutropenia/Agranulocytosis: Another ACE inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment, especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Foreign marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Precautions: *General: Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with ACE inhibitors, including VASOTEC, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20% of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients, renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when VASOTEC has been given concomitantly with a diuretic. This is more likely to occur in patients with preexisting renal impairment. Dosage reduction and/or discontinuation of the diuretic and/or VASOTEC may be required.

Evaluation of patients with hypertension or heart failure should always include assessment of renal function. (See DOSAGE AND ADMINISTRATION.)

Hyperkalemia: Elevated serum potassium (>5.7 mEq/L) was observed in approximately 1% of hypertensive patients in clinical trials. In most cases these were isolated values which resolved despite continued therapy. Hyperkalemia was a cause of discontinuation of therapy in 0.28% of hypertensive patients. In clinical trials in heart failure, hyperkalemia was observed in 3.8% of patients, but was not a cause for discontinuation.

Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with VASOTEC. (See *Drug Interactions.*)

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Information for Patients:

Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness, especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

NOTE: As with many other drugs, certain advice to patients being treated with enalapril is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions:

Hypotension: Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide close medical supervision after the initial dose for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and DOSAGE AND ADMINISTRATION.)

Agents Causing Renin Release: The antihypertensive effect of VASOTEC is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: VASOTEC has been used concomitantly with beta-adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine, prazosin, and digoxin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: VASOTEC attenuates potassium loss caused by thiazide-type diuretics. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia, they should be used with caution and with frequent monitoring of serum potassium. Potassium-sparing agents should generally not be used in patients with heart failure receiving VASOTEC.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant VASOTEC and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Pregnancy—Category C: There was no fetotoxicity or teratogenicity in rats treated with up to 200 mg/kg/day of enalapril (333 times the maximum human dose). Fetotoxicity, expressed as a decrease in average fetal weight, occurred in rats given 1200 mg/kg/day of enalapril but did not occur when these animals were supplemented with saline. Enalapril was not teratogenic in rabbits. However, maternal and fetal toxicity occurred in some rabbits at doses of 1 mg/kg/day or more. Saline supplementation prevented the maternal and fetal toxicity seen at doses of 3 and 10 mg/kg/day, but not at 30 mg/kg/day (50 times the maximum human dose).

Radioactivity was found to cross the placenta following administration of labeled enalapril to pregnant hamsters.

There are no adequate and well-controlled studies of enalapril in pregnant women. However, data are available that show enalapril crosses the human placenta. Because the risk of fetal toxicity with the use of ACE inhibitors has not been clearly defined, VASOTEC® (Enalapril Maleate, MSD) should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Postmarketing experience with all ACE inhibitors thus far suggests the following with regard to pregnancy outcome. Inadvertent exposure limited to the first trimester of pregnancy has not been reported to affect fetal outcome adversely. Fetal exposure during the second and third trimesters of pregnancy has been associated with fetal and neonatal morbidity and mortality.

When ACE inhibitors are used during the later stages of pregnancy, there have been reports of hypotension and decreased renal perfusion in the newborn. Oligohydramnios in the mother has also been reported, presumably representing decreased renal function in the fetus. Infants exposed *in utero* to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion with the administration of fluids and pressors as appropriate. Problems associated with prematurity such as patent ductus arteriosus have occurred in association with maternal use of ACE inhibitors, but it is not clear whether they are related to ACE inhibition, maternal hypertension, or the underlying prematurity.

Nursing Mothers: Milk in lactating rats contains radioactivity following administration of ^{14}C enalapril maleate. It is not known whether this drug is secreted in human milk. Because many drugs are secreted in human milk, caution should be exercised when VASOTEC is given to a nursing mother.

Pediatric Use: Safety and effectiveness in children have not been established.

Adverse Reactions: VASOTEC has been evaluated for safety in more than 10,000 patients, including over 1000 patients treated for one year or more. VASOTEC has been found to be generally well tolerated in controlled clinical trials involving 2987 patients.

HYPERTENSION: The most frequent clinical adverse experiences in controlled trials were: headache (5.2%), dizziness (4.3%), and fatigue (3%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in controlled clinical trials were: diarrhea (1.4%), nausea (1.4%), rash (1.4%), cough (1.3%), orthostatic effects (1.2%), and asthenia (1.1%).

HEART FAILURE: The most frequent clinical adverse experiences in both controlled and uncontrolled trials were: dizziness (7.9%), hypotension (6.7%), orthostatic effects (2.2%), syncope (2.2%), cough (2.2%), chest pain (2.1%), and diarrhea (2.1%).

Other adverse experiences occurring in greater than 1% of patients treated with VASOTEC in both controlled and uncontrolled clinical trials were: fatigue (1.8%), headache (1.8%), abdominal pain (1.6%), asthenia (1.6%), orthostatic hypotension (1.6%), vertigo (1.6%), angina pectoris (1.5%), nausea (1.3%), vomiting (1.3%), bronchitis (1.3%), dyspnea (1.3%), urinary tract infection (1.3%), rash (1.3%), and myocardial infarction (1.2%).

Other serious clinical adverse experiences occurring since the drug was marketed or adverse experiences occurring in 0.5% to 1% of patients with hypertension or heart failure in clinical trials in order of decreasing severity within each category:

Cardiovascular: Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high-risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances; atrial fibrillation, palpitation.

Digestive: Ileus, pancreatitis, hepatitis (hepatocellular or cholestatic jaundice), melena, anorexia, dyspepsia, constipation, glossitis, stomatitis, dry mouth.

Musculoskeletal: Muscle cramps.

Nervous/Psychiatric: Depression, confusion, ataxia, somnolence, insomnia, nervousness, paresthesia.

Urogenital: Renal failure, oliguria, renal dysfunction (see PRECAUTIONS and DOSAGE AND ADMINISTRATION).

Respiratory: Bronchospasm, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection.

Skin: Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pruritus, alopecia, flushing, hyperhidrosis.

Special Senses: Blurred vision, taste alteration, anosmia, tinnitus, conjunctivitis, dry eyes, tearing.

A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgias/arthritis, myalgias, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash, and other dermatologic manifestations.

Angioedema: Angioedema has been reported in patients receiving VASOTEC (0.2%). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis, and/or larynx occurs, treatment with VASOTEC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In the hypertensive patients, hypotension occurred in 0.9% and syncope occurred in 0.5% of patients following the initial dose or during extended therapy. Hypotension or syncope was a cause for discontinuation of therapy in 0.1% of hypertensive patients. In heart failure patients, hypotension occurred in 6.7% and syncope occurred in 2.2% of patients. Hypotension or syncope was a cause for discontinuation of therapy in 1.9% of patients with heart failure. (See WARNINGS.)

Clinical Laboratory Test Findings:

Serum Electrolytes: Hyperkalemia (see PRECAUTIONS), hyponatremia.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials, minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.2% of patients with essential hypertension treated with VASOTEC alone. Increases are more likely to occur in patients receiving concomitant diuretics or in patients with renal artery stenosis. (See PRECAUTIONS.) In patients with heart failure who were also receiving diuretics with or without digitalis, increases in blood urea nitrogen or serum creatinine, usually reversible upon discontinuation of VASOTEC and/or other concomitant diuretic therapy, were observed in about 11% of patients. Increases in blood urea nitrogen or creatinine were a cause for discontinuation in 1.2% of patients.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g% and 1.0 vol %, respectively) occur frequently in either hypertension or heart failure patients treated with VASOTEC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1% of patients discontinued therapy due to anemia.

Other (Causal Relationship Unknown): In marketing experience, rare cases of neutropenia, thrombocytopenia, and bone marrow depression have been reported. A few cases of hemolysis have been reported in patients with G6PD deficiency.

Liver Function Tests: Elevations of liver enzymes and/or serum bilirubin have occurred.

Dosage and Administration: *Hypertension:* In patients who are currently being treated with a diuretic, symptomatic hypotension occasionally may occur following the initial dose of VASOTEC. The diuretic should, if possible, be discontinued for two to three days before beginning therapy with VASOTEC to reduce the likelihood of hypotension. (See WARNINGS.) If the patient's blood pressure is not controlled with VASOTEC alone, diuretic therapy may be resumed.

If the diuretic cannot be discontinued, an initial dose of 2.5 mg should be used under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*)

The recommended initial dose in patients not on diuretics is 5 mg once a day. Dosage should be adjusted according to blood pressure response. The usual dosage range is 10 to 40 mg per day administered in a single dose or in two divided doses. In some patients treated once daily, the antihypertensive effect may diminish toward the end of the dosing interval. In such patients, an increase in dosage or twice-daily administration should be considered. If blood pressure is not controlled with VASOTEC alone, a diuretic may be added.

Concomitant administration of VASOTEC with potassium supplements, potassium salt substitutes, or potassium-sparing diuretics may lead to increases of serum potassium (see PRECAUTIONS).

Dosage Adjustment in Hypertensive Patients with Renal Impairment: The usual dose of enalapril is recommended for patients with a creatinine clearance > 30 mL/min (serum creatinine of up to approximately 3 mg/dL). For patients with creatinine clearance ≤ 30 mL/min (serum creatinine ≥ 3 mg/dL), the first dose is 2.5 mg once daily. The dosage may be titrated upward until blood pressure is controlled or to a maximum of 40 mg daily.

Heart Failure: VASOTEC is indicated as adjunctive therapy with diuretics and digitalis. The recommended starting dose is 2.5 mg once or twice daily. After the initial dose of VASOTEC, the patient should be observed under medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS and PRECAUTIONS, *Drug Interactions.*) If possible, the dose of the diuretic should be reduced, which may diminish the likelihood of hypotension. The appearance of hypotension after the initial dose of VASOTEC does not preclude subsequent careful dose titration with the drug, following effective management of the hypotension. The usual therapeutic dosing range for the treatment of heart failure is 5 to 20 mg daily given in two divided doses. The maximum daily dose is 40 mg. Once-daily dosing has been effective in a controlled study, but nearly all patients in this study were given 40 mg, the maximum recommended daily dose, and there has been much more experience with twice-daily dosing. In addition, in a placebo-controlled study which demonstrated reduced mortality in patients with severe heart failure (NYHA Class IV), patients were treated with 2.5 to 40 mg per day of VASOTEC, almost always administered in two divided doses. (See CLINICAL PHARMACOLOGY, *Pharmacodynamics and Clinical Effects.*) Dosage may be adjusted depending upon clinical or hemodynamic response. (See WARNINGS.)

Dosage Adjustment in Patients with Heart Failure and Renal Impairment or Hyponatremia: In patients with heart failure who have hyponatremia (serum sodium < 130 mEq/L) or with serum creatinine >1.6 mg/dL, therapy should be initiated at 2.5 mg daily under close medical supervision. (See DOSAGE AND ADMINISTRATION, *Heart Failure*, WARNINGS, and PRECAUTIONS, *Drug Interactions.*) The dose may be increased to 2.5 mg b.i.d., then 5 mg b.i.d. and higher as needed, usually at intervals of four days or more, if at the time of dosage adjustment there is not excessive hypotension or significant deterioration of renal function. The maximum daily dose is 40 mg.

For more detailed information, consult your MSD Representative or see Prescribing Information, Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, PA 19486. J9VS61R2(820)

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A diminished antihypertensive effect toward the end of the dosing interval can occur in some patients.

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